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SPECIAL EDUCATION AND REHABILITATION

HEARINGS BEFORE THE SUBCOMMITTEE ON SPECIAL EDUCATION OF THE COMMITTEE ON EDUCATION AND LABOR HOUSE OF REPRESENTATIVES

EIGHTY-SIXTH CONGRESS

FIRST SESSION

ON

H.R. 1119, H.R. 3465, H.J. Res. 488, H.J. Res. 494

BILLS REGARDING THE FIELD OF SPECIAL
EDUCATION AND REHABILITATION

PART 1

HEARINGS HELD IN NEW YORK, N.Y., OCTOBER 28 AND 29, 1959

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SPECIAL EDUCATION AND REHABILITATION

WEDNESDAY, OCTOBER 28, 1959

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON SPECIAL EDUCATION OF THE
COMMITTEE ON EDUCATION AND LABOR,
New York, N.Y.

The subcommittee met at 10 a.m. pursuant to call, at the 71st Regiment Armory, Park Avenue and 34th Street, Hon. Carl Elliott (chairman of the subcommittee) presiding.

Present: Representatives Barden, Elliott, Daniels, Giaimo, and Lafore.

Also present: Representative John V. Lindsay.

Staff member present: Mary P. Allen, clerk, Subcommittee on Special Education.

Mr. ELLIOTT. The Subcommittee on Special Education of the House Committee on Education and Labor will come to order.

My name is Carl Elliott, and I represent the Seventh Congressional District of Alabama.

On my right is Congressman Dominick V. Daniels, a Member of Congress from the State of New Jersey, and on his right is Robert N. Giaimo, a Member of Congress from Connecticut.

On our committee, also, is Congressman John Lafore of Pennsylvania, who will be here shortly; Congressman Wainwright of New York, who has been unavoidably delayed, but who will arrive later today. We will be honored to have present sometime during the course of our hearings the chairman of our full committee, the Committee on Education and Labor, the Honorable Graham A. Barden of North Carolina.

Congressman Zelenko of the 21st District of New York is also a member of this committee, and will be present to sit with the subcommittee during some of the time that we are here.

Congressman John Lindsay will sit with the subcommittee today. These hearings are being held in his congressional district, the 17th District of New York, and we are happy to welcome Mr. Lindsay to participate in our hearings.

The purpose of these hearings, as most of you know, is to receive testimony on the urgent needs, national and local, in the fields of special education and rehabilitation and to get specific suggestions as to how the Federal Government might aid in solving some of these problems.

The subcommittee also has pending before it several bills concerning the field of rehabilitation and special education, and we will be glad to receive comments on these specific measures: H.R. 3465, by myself; H.R. 1119, by Congressman Fogarty; House Joint Resolution 494, and House Joint Resolution 488. These bills will be made a part

of the record immediately following the present statement that I am making.

The hearings are scheduled for today, tomorrow, and Friday, if necessary. I presume it will be necessary that the hearings go over to the 30th, because I note from my list that we have a schedule of 31 witnesses for today. In order to hear 31 witnesses, it is necessary that we proceed right along with about 10 minutes to each witness.

Witnesses will be allowed to file their written statements in full. I would like to suggest to each witness that he be prepared to summarize in about 6 minutes his statement, and that he then file his full statement for the record. The remaining 4 minutes of the witness will be used for questioning. There will be 6 minutes for the summary, 4 minutes for the questioning, and then file the full written statement for the record. In that manner we will be able to proceed right along.

(The bills and joint resolutions referred to follow:)

[H.R. 3465, 86th Cong., 1st sess.]

A BILL To provide evaluation of rehabilitation potentials and rehabilitation services to handicapped individuals who as a result thereof can achieve such ability of independent living as to dispense with the need for expensive institutional care or who can dispense with or largely dispense with the need of an attendant at home; to assist in the establishment of public and private nonprofit workshops and rehabilitation facilities; and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Rehabilitation Act of 1959."

FINDING OF FACT AND DECLARATION

The Congress hereby finds and declares—

(1) that many severely handicapped persons, including the mentally ill or retarded, and older persons, ineligible for vocational rehabilitation, as a result of independent living rehabilitation services can achieve such a degree of independence that—

- (a) their institutional care can be terminated, or
- (b) their need for an attendant's care at home will be ended or substantially reduced, and
- (c) in many instances these individuals will be found to be capable of vocational rehabilitation and will become gainfully employed taxpayers;

(2) that the provision of independent living rehabilitation services to such severely handicapped persons ends or minimizes the public and family burden of providing them with attendant's care, contributes greatly to their dignity and self-respect, and is in the public interest;

(3) that there is a grave shortage of rehabilitation facilities where independent living and vocational rehabilitation services are provided the severely handicapped, including hearing and speech correction, fitting and use of prosthetic devices, adjustment, prevocational and vocational training, and particularly of centers providing a variety of such services,

(4) that there is a grave shortage of sheltered workshop facilities wherein work capacities of severely handicapped can be evaluated and developed, and can also be utilized in productive work in cases where the handicapped individual is not absorbable in the competitive labor market; and

(5) that Federal grants assisting in the provision of the foregoing rehabilitation facilities and services are required in the public interest as a necessary expansion of present grants under the Vocational Rehabilitation Act.

SEC. 2. (a) The Vocational Rehabilitation Act, as amended by the Vocational Rehabilitation Amendments of 1954 (29 U.S.C., ch. 4), is amended (a) by inserting at the beginning thereof the heading "TITLE I", (b) by striking out the phrase "this Act" wherever it appears, and inserting in lieu thereof "this title", by inserting before the period at the end of section 11(a) the following: "*Provided*, That vocational rehabilitation services shall not include any evaluation services with respect to which grants have been qualified for by the State and

have been, or will be paid, under title IV of this Act" and (c) by adding the following after section 3(c):

"(d) In the event of failure of any State or States to qualify in a fiscal year for any payment under this section or to qualify for a payment in an amount less than the amount of the State's allotment, the amount equal to the total of each such State's allotment, or the difference between its allotment and its payment, as the case may be, shall be reallocated among the remaining States on the basis of their respective population."

SEC. 3. The Vocational Rehabilitation Act, as amended by the Vocational Rehabilitation Amendments of 1954, is further amended by adding at the end thereof three new titles as follows:

"TITLE II—INDEPENDENT LIVING REHABILITATION SERVICES

"AUTHORIZATION OF APPROPRIATIONS FOR GRANTS, PURPOSE FOR WHICH AVAILABLE

"SEC. 201. For the purpose of assisting the States in rehabilitating handicapped individuals who, as a result of such rehabilitation, may be expected to achieve such ability of independent living as to dispense with, or largely dispense with, the need for institutional care or, if not institutionalized, to dispense with, or largely dispense with, the need for an attendant, thereby reducing their burden upon others and contributing to their dignity and self-respect, there is hereby authorized for the fiscal year ending June 30, 1960, \$10,000,000; for the fiscal year ending June 30, 1961, \$20,000,000; and for each fiscal year thereafter such sums as Congress may determine necessary to carry out the purposes of this title.

"GRANTS FOR INDEPENDENT LIVING REHABILITATION SERVICES

"SEC. 202. (a) From the sums made available under section 201 to assist States in meeting the costs of independent living rehabilitation services, each State shall be entitled to an allotment of an amount which bears the same ratio to such sums as the product of the population of the State and the square of its allotment percentage (as defined in section 11(h) of title I) bears to the sum of the corresponding products for all the States. The allotment to any State under an allotment for any year which is less than \$25,000, or in the case of the Virgin Islands is less than \$10,000 (or such other amount as may be specified in a minimum allotment in the Act appropriating such sums for such year), shall be increased to that amount, the total of the increases thereby required being derived by proportionately reducing the allotments to each of the remaining States, but with such adjustments as may be necessary to prevent the allotments of any such remaining States from being thereby reduced below that amount. In the event of failure of any State or States to qualify in a fiscal year for any payment under this section or to qualify for a payment in an amount less than the amount of the State's allotment, the amount equal to the total of each such State's allotment, or the difference between its allotment and its payment, as the case may be, shall be reallocated among the remaining States.

"(b) From each State's allotment under this section, as determined by the Secretary of Health, Education, and Welfare (hereinafter called the Secretary), the Secretary shall pay to such State an amount equal to the Federal share (determined as provided in section 11(1) of title I of this Act) of the cost, including cost of administration, of independent living rehabilitation services provided under the independent living rehabilitation plan approved under section 203 of this title, which such plan is incorporated in the State plan approved under section 5 of title I of this Act.

"STATE INDEPENDENT LIVING REHABILITATION PLANS

"SEC. 203. (a) To be approved under this title, a State plan for independent living rehabilitation services shall—

"(1) designate the State agency administering or supervising the administration of vocational education in the State, or a State rehabilitation agency (primarily concerned with vocational rehabilitation), as the sole State agency to administer the plan, or to supervise its administration to the extent that any part thereof is administered in local areas by any public agency pursuant to contract, except that where under the State's law the State blind commission, or other agency which provides assistance or services to the adult blind, is authorized to provide them vocational rehabilitation

services, such State blind commission or other State agency may be designated as the sole State agency to administer the part of the plan under which vocational rehabilitation services are provided for the blind (or to supervise the administration of such part in a political subdivision of the State by a sole local agency of such political subdivision) and the State vocational education agency or the State rehabilitation agency shall be designated as the sole State agency with respect to the rest of the State plan;

"(2) provide for financial participation of the State, which may include non-State funds which the State plan specifies may be accepted by the State agency;

"(3) provide such methods of administration, other than methods relating to the establishment and maintenance of personnel standards, as are found by the Secretary to be necessary for the proper and efficient administration of the plan;

"(4) contain (A) provisions relating to the establishment and maintenance of personnel standards, including provisions relating to the tenure, selection, appointment, and qualification of personnel, and (B) provisions relating to the establishment and maintenance of minimum standards governing the facilities and personnel utilized in the provision of independent living rehabilitation services, but the Secretary shall exercise no authority with respect to the selection, method of selection, tenure of office, or compensation of any individual employed in accordance with such provisions;

"(5) show the plan, policies, and methods to be followed in carrying out the work under the State plan and in its administration and supervision and, in case independent living rehabilitation services cannot be provided all eligible physically handicapped individuals who apply for such services, show the order to be followed in selecting those to whom independent living rehabilitation services will be provided;

"(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time reasonably require to carry out his functions under this Act, and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of such reports;

"(7) provide for cooperation by the State agency with, and the utilization of the services of, the State agencies administering the State's public assistance and public health programs, and the Bureau of Old-Age and Survivors Insurance (Department of Health, Education, and Welfare) and of other Federal, State, and local public agencies providing services relating to independent living rehabilitation services.

"(b) The Secretary shall approve any plan which he finds fulfills the conditions specified in subsection (a) of this section which is submitted as an addition to a State plan for vocational rehabilitation approved by the Secretary under title I of this Act.

"(c) Whenever the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this section, finds that—

"(1) the plan has been so changed that it no longer complies with the requirements of subsection (a) of this section; or

"(2) in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that no further payments will be made to the State under this title until he is satisfied that there is no longer any such failure. Until he is so satisfied, the Secretary shall make no further payment to such State under this title.

"(d) If any State is dissatisfied with the Secretary's action under subsection (c) of this section, such State may appeal to the United States district court for the district where the capital of such State is located, and judicial review of such action shall be had on the record in accordance with the provisions of the Administrative Procedure Act.

"METHOD OF COMPUTING AND MAKING PAYMENTS

"Sec. 204. The method of computing and paying amounts pursuant to this title shall be as follows:

"(a) The Secretary shall, prior to the beginning of each calendar quarter or other period prescribed by him, estimate the amount to be paid to each State

under the provisions of this title for such period, such estimate to be based on such records of the State and information furnished by it, and such other investigation as the Secretary may find necessary.

"(b) The Secretary shall pay, from the allotment available therefor, the amount so estimated by him for such period, reduced or increased, as the case may be, by any sum (not previously adjusted under this paragraph) by which he finds that his estimate of the amount to be paid the State for any prior period under this title was greater or less than the amount which should have been paid to the State for such prior period under this title. Such payments shall be made prior to audit or settlement by the General Accounting Office, shall be made through the disbursing facilities of the Treasury Department, and shall be made in such installments as the Secretary may determine.

"ADMINISTRATION

"SEC. 205. (a) In carrying out his duties under this Act, the Secretary shall—

"(1) make studies, investigations, demonstrations, and reports with respect to programs of independent living rehabilitation services carried on under this title;

"(2) cooperate with and render technical assistance to States in matters relating to the independent living rehabilitation of physically and mentally handicapped individuals;

"(3) provide training and instruction in technical matters relating to independent living rehabilitation services, including the establishment and maintenance of such research fellowships and traineeships, with such stipends and allowances (including travel and subsistence expenses), as he may deem necessary;

"(4) disseminate information as to the studies, investigations, demonstrations, and reports referred to in paragraph (1) and other matters relating to independent living rehabilitation services.

"(b) The Secretary is authorized to make rules and regulations governing the administration of this Act, and to delegate to any officer or employee of the United States such of his powers and duties, except the making of rules and regulations, as he finds necessary in carrying out the purposes of this Act.

"DEFINITIONS

"SEC. 206. For the purpose of this title—

"(a) The term 'independent living rehabilitation services' means counseling, psychological and related services (including transportation) rendered seriously handicapped individuals and in the case of any such individual found to require financial assistance with respect thereto, after full consideration of his eligibility for any similar benefits by way of pension, compensation, and insurance, such term shall include physical restoration and related services, including corrective surgery, therapeutic treatment, and hospitalization, needed prosthetic appliances and other devices which will contribute to independent living and training in the use thereof, and maintenance needed to assure the availability of such services.

"(b) The term 'handicapped individual' means an individual of employable age, as defined by regulations of the Secretary, who is under such physical or mental disability as to require institutional care or attendance in his household continuously or for a substantial portion of the time, but who can be reasonably expected, as a result of rehabilitation services to achieve such ability of independent living that he will no longer require such institutional care or such attendance in his household.

"(c) The term 'State' includes Alaska, District of Columbia, Hawaii, Virgin Islands, Puerto Rico, and Guam.

"TITLE III—WORKSHOPS AND REHABILITATION FACILITIES

"AUTHORIZATION OF APPROPRIATIONS FOR GRANTS; PURPOSES FOR WHICH AVAILABLE

"SEC. 301. (a) For the purpose of encouraging and assisting in the establishment of public and other nonprofit workshops and rehabilitation facilities needed in rehabilitating physically and mentally handicapped individuals, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1960, the sum of \$10,000,000; for the fiscal year ending June 30, 1961, \$12,500,000; for the fiscal

year ending June 30, 1962, \$15,000,000 and for each fiscal year thereafter such sums as Congress may determine, for grants to carry out the purpose of this title, including any amounts which may be specifically appropriated for area facilities.

"(b) In making grants hereunder, except from funds specifically appropriated for and limited to area facilities, the Secretary of Health, Education, and Welfare, hereinafter called the Secretary, shall, insofar as practical and consistent with the purposes of this Act, distribute grants for projects in the several States in aggregate amounts proportionate to their respective populations, and in no event shall grants hereunder to a State exceed by more than 50 per centum the aggregate amount it would receive on such population basis or \$10,000, whichever is greater: *Provided*, That in any case where the Secretary of Health, Education, and Welfare finds that any State or States has no project, or insufficient projects, to utilize fully the amount it would utilize in a fiscal year, he may, after January 1 of such year redistribute the funds which would otherwise have been paid such State to other States for suitable projects and such distribution need not be proportionate to State populations.

"(c) As used in this section 'area facilities' means facilities intended to serve areas which include all or parts of two or more States.

"GRANTS FOR ESTABLISHMENT OF WORKSHOPS AND REHABILITATION FACILITIES

"SEC. 302. (a) From the sums made available pursuant to section 301 of this title, the Secretary shall make grants for paying part of the costs incurred in the establishment of nonprofit workshops and rehabilitation facilities as hereafter defined and limited in subsections (b) and (c) hereof, and subject to the conditions and requirements of section 303 of this title. Such grants shall be available for payment of administrative expenses found by the Secretary to be necessary in connection with performance by the State of its functions under this title.

"(b) Nonprofit workshops and rehabilitation facilities with respect to which grants may be made pursuant to subsection (a) hereof, shall include but not be limited to—

"(1) nonprofit workshops where any manufacture or handiwork is carried on, and which are operated for the primary purpose of providing one or more of the following:

"(A) remunerate employment to severely handicapped individuals as an interim step in the rehabilitation process for those who cannot readily be absorbed in the competitive labor market, or during such time as employment opportunities for them in the competitive labor market do not exist;

"(B) an opportunity for evaluating the work potential and developing the work capacity of handicapped individuals; or

"(C) employment for handicapped individuals confined to their homes.

"(2) nonprofit rehabilitation facilities operated for the primary purpose of assisting in the rehabilitation of physically and mentally handicapped individuals—

"(A) which provide one or more of the following types of services:

"(i) testing, fitting, or training in the use of prosthetic devices;

"(ii) vocational training;

"(iii) prevocational or conditioning therapy;

"(iv) physical, occupational, or other medically supervised therapy;

"(v) adjustment training; or

"(vi) evaluation or control of special disabilities; or

"(B) through which is provided an integrated program of medical, psychological, social, and vocational evaluation and services under competent professional supervision: *Provided*, That the major portion of such evaluation and services is furnished within the facility and that all medical and related health services are prescribed by, or are under the formal supervision of, persons licensed to practice medicine or surgery in the State.

"(b) Grants shall be made with respect to construction or alternation of buildings and procurement or installation of initial equipment necessary to establish or increase their effectiveness as workshops or rehabilitation facilities, and staffing for a period not to exceed two years. Grants shall be subject to such limitations and conditions as the Secretary of Health, Education, and Wel-

fare shall prescribe to assure minimum standards for facilities and personnel under this Act, including a system of priorities for the approval of projects.

"(c) The Federal share of cost of the workshop or rehabilitation facility established under this title shall not exceed two dollars for each one dollar which is otherwise obtained and used toward defraying such cost.

"(d) No grant shall be made under this title with respect to any workshop or rehabilitation facility unless—

"(1) application therefor in such form and containing such data and assurances as are required by the Secretary has been transmitted through and approved as feasible and necessary for vocational rehabilitation by the State agency designated pursuant to section 5(a) (1) of title I of the State where such workshop or other rehabilitation facility is located or to be located;

"(2) the Secretary finds that the facility with respect to which such grant is requested is feasible, is needed, and that Federal grants for its establishment are not available under any other Federal law;

"(3) the Secretary finds that wages paid handicapped workers meet wage and hour standards administered by the United States Department of Labor;

"(4) the Secretary requires, and the applicant provides, such assurances, in such form and with such provisions as the Secretary finds necessary to insure that the purpose of such grant will be carried out and that its conditions and limitations of such grant will be complied with.

"TITLE IV—REHABILITATION EVALUATION SERVICES

"AUTHORIZATION FOR APPROPRIATIONS

"SEC. 401. For the purpose of assisting the States in evaluating the nature and extent of the disabilities and the rehabilitation potentials of individuals of employable age, as defined in regulations of the Secretary of Health, Education, and Welfare, whose application therefor shows that they are under a substantial physical or mental handicap which may be overcome or substantially reduced by vocational rehabilitation services available under title I of this Act or otherwise available, or whose dependency may be overcome or substantially reduced by independent living rehabilitation services available under title II hereof, or otherwise available, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1959, and for each fiscal year thereafter, such sums as are necessary for grants to States to carry out the purpose of this title.

"PAYMENTS TO STATES

"SEC. 402. (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has an approved plan for vocational rehabilitation (under title I of this Act) and for independent living rehabilitation services (under title II of this Act), for each fiscal year an amount equal to two-thirds of the total of the sums expended by the State agency or agencies administering such plans during such year, including administrative costs thereof, as found necessary by the Secretary of Health, Education, and Welfare, for the proper and efficient evaluation of disabilities and rehabilitation potentials referred to in section 401.

"(b) The Secretary of Health, Education, and Welfare shall, prior to the beginning of each quarter, or such other period as he shall prescribe as appropriate, estimate the amount to be paid with respect to expenditures for such evaluations in such period, such estimate to be based on (1) a report filed by such State agency or agencies containing the estimates of such expenditures, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such period, and if such amount is less than the State's proportionate sum of such estimated expenditures, the sources from which the difference is expected to be derived, (2) records of the number of applicants for rehabilitation evaluation, and (3) such other records and reports as the Secretary may find necessary.

"(c) The Secretary of Health, Education, and Welfare shall then certify to the Secretary of the Treasury the amount so estimated by the Secretary of Health, Education, and Welfare, (A) reduced or increased, as the case may be, by any sum by which the Secretary of Health, Education, and Welfare finds that his estimate for any prior period was greater or less than the amount which should have been paid to the State under subsection (a) for such period;

except that such increases or reductions shall not be made to the extent that such sums have been applied to make the amount certified for any prior period greater or less than the amount estimated by the Secretary of Health, Education, and Welfare for such prior period.

"The Secretary of the Treasury shall thereupon, through the fiscal service of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary of Health, Education, and Welfare, the amount so certified.

"(d) Payments hereunder shall not be made to a State with respect to any period for which the Secretary refuses payment of grants to such State under title I or II hereof pursuant to the provisions of such titles.

"DEFINITION OF REHABILITATION EVALUATION SERVICES

"SEC. 403. The term 'rehabilitation evaluation services' means (1) diagnostic and related services (including transportation) incidental to the determination of the nature and extent of an individual's physical and mental impairment and rehabilitation potentials and the rehabilitation services required to realize these potentials, (2) the determination of appropriate referral of such individual for vocational rehabilitation services as defined in title I of this Act, independent living rehabilitation services as defined in title II of this Act, or other needed services provided by public or private agencies. In the case of individuals found to require financial assistance with respect thereto such term also includes maintenance during any period he is required to be away from home during the period diagnostic and other evaluation services are being provided."

RESEARCH AND DEMONSTRATION PROJECTS

SEC. 5. The part of the first sentence of section 4(a) of the Vocational Rehabilitation Act as amended by the Vocational Rehabilitation Amendments of 1954 (Public Law 565, Eighty-third Congress, 29 U.S.C., ch. 4) which reads: "(1) For paying part of" is amended to read "(1) For paying or sharing in".

PRESIDENT'S COMMITTEE ON THE EMPLOYMENT OF THE PHYSICALLY HANDICAPPED

SEC. 6. The joint resolution entitled "Joint resolution authorizing an appropriation for the work of the President's Committee on National Employment of the Physically Handicapped Week", approved July 11, 1949 (63 Stat. 409), as amended, is amended by striking out "\$225,000" and inserting in lieu thereof "\$300,000."

[H.R. 1119, 86th Cong., 1st sess.]

A BILL To provide evaluation of rehabilitation potentials and rehabilitation services to handicapped individuals who as a result thereof can achieve such ability of independent living as to dispense with the need for expensive institutional care or who can dispense with or largely dispense with the need of an attendant at home; to assist in the establishment of public and private nonprofit workshops and rehabilitation facilities; and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Rehabilitation Act of 1959".

FINDINGS OF FACT AND DECLARATION

The Congress hereby finds and declares—

(1) that many severely handicapped persons, including the mentally ill or retarded, and older persons, ineligible for vocational rehabilitation, as a result of independent living rehabilitation services can achieve such a degree of independence that—

(a) their institutional care can be terminated, or

(b) their need for an attendant's care at home will be ended or substantially reduced, and

(c) in many instances these individuals will be found to be capable of vocational rehabilitation and will become gainfully employed taxpayers;

(2) that the provision of independent living rehabilitation services to such severely handicapped persons ends or minimizes the public and family burden of providing them with attendant's care, contributes greatly to their dignity and self-respect, and is in the public interest;

(3) that there is a grave shortage of rehabilitation facilities where independent living and vocational rehabilitation services are provided the severely handicapped, including hearing and speech correction; fitting and use of prosthetic devices, adjustment, prevocational and vocational training, and particularly of centers providing a variety of such service;

(4) that there is a grave shortage of sheltered workshop facilities wherein work capacities of severely handicapped can be evaluated and developed, and can also be utilized in productive work in cases where the handicapped individual is not absorbable in the competitive labor market; and

(5) that Federal grants assisting in the provision of the foregoing rehabilitation facilities and services are required in the public interest as a necessary expansion of present grants under the Vocational Rehabilitation Act.

SEC. 2. (a) The Vocational Rehabilitation Act, as amended by the Vocational Rehabilitation Amendments of 1954 (29 U.S.C., ch. 4), is amended (a) by inserting at the beginning thereof the heading "TITLE I", (b) striking out the phrase "this Act" wherever it appears, and inserting in lieu thereof "this title", by inserting before the period at the end of section 11(a) the following: "*Provided*, That vocational rehabilitation services shall not include any evaluation service with respect to which grants have been qualified for by the State and have been or will be paid under title IV of this Act", and (c) by adding the following after section 3(c):

"(d) In the event of failure of any State or States to qualify in a fiscal year for any payment under this section or to qualify for a payment in an amount less than the amount of the State's allotment, the amount equal to the total of each such State's allotment, or the difference between its allotment and its payment, as the case may be, shall be reallocated among the remaining States on the basis of their respective population."

SEC. 3. The Vocational Rehabilitation Act, as amended by the Vocational Rehabilitation Amendments of 1954, is further amended by adding at the end thereof three new titles as follows.

"TITLE II—INDEPENDENT LIVING REHABILITATION SERVICES

"AUTHORIZATION OF APPROPRIATIONS FOR GRANTS, PURPOSE FOR WHICH AVAILABLE

"SEC. 201. For the purpose of assisting the States in rehabilitating handicapped individuals who, as a result of such rehabilitation, may be expected to achieve such ability of independent living as to dispense with, or largely dispense with, the need for institutional care or, if not institutionalized, to dispense with, or largely dispense with, the need for an attendant, thereby reducing their burden upon others and contributing to their dignity and self-respect, there is hereby authorized for the fiscal year ending June 30, 1958, \$10,000,000; for the fiscal year ending June 30, 1959, \$20,000,000; and for each fiscal year thereafter such sums as Congress may determine necessary to carry out of the purposes of this title.

"GRANTS FOR INDEPENDENT LIVING REHABILITATION SERVICES

"SEC. 202. (a) From the sums made available under section 201 to assist States in meeting the costs of independent living rehabilitation services, each State shall be entitled to an allotment of an amount which bears the same ratio to such sums as the product of the population of the State and the square of its allotment percentage (as defined in section 11(h) of title I) bears to the sum of the corresponding products for all the States. The allotment to any State under an allotment for any year which is less than \$25,000, or in the case of the Virgin Islands is less than \$10,000 (or such other amount as may be specified in a minimum allotment in the Act appropriating such sums for such year), shall be increased to that amount, the total of the increases thereby required being derived by proportionately reducing the allotments to each of the remaining States, but with such adjustments as may be necessary to prevent the allotments of any such remaining States from being thereby reduced below that amount. In the event of failure of any State or States to qualify in a fiscal year for any payment under this section or to qualify for a payment in an amount less than the amount of the State's allotment, the amount equal to the total of each such State's allotment, or the difference between its allotment and its payment, as the case may be, shall be reallocated among the remaining States.

"(b) From each State's allotment under this section, as determined by the Secretary of Health, Education, and Welfare (hereinafter called the Secretary), the Secretary shall pay to such State an amount equal to the Federal share (determined as provided in section 11(1) of title I of this Act) of the cost, including cost of administration, of independent living rehabilitation services provided under the independent living rehabilitation plan approved under section 203 of this title, which such plan is incorporated in the State plan approved under section 5 of title I of this Act.

"STATE INDEPENDENT LIVING REHABILITATION PLANS

"SEC. 203. (a) To be approved under this title, a State plan for independent living rehabilitation services shall—

"(1) designate the State agency administering or supervising the administration of vocational education in the State, or a State rehabilitation agency (primarily concerned with vocational rehabilitation) as the sole State agency to administer the plan, or to supervise its administration to the extent that any part thereof is administered in local areas by any public agency pursuant to contract, except that where under the State's law the State blind commission, or other agency which provides assistance or services to the adult blind, is authorized to provide them vocational rehabilitation services, such State blind commission or other State agency may be designated as the sole State agency to administer the part of the plan under which vocational rehabilitation services are provided for the blind (or to supervise the administration of such part in a political subdivision of the State by a sole local agency of such political subdivision) and the State vocational education agency or the State rehabilitation agency shall be designated as the sole State agency with respect to the rest of the State plan;

"(2) provide for financial participation of the State, which may include non-State funds which the State plan specifies may be accepted by the State agency;

"(3) provide such methods of administration, other than methods relating to the establishment and maintenance of personnel standards, as are found by the Secretary to be necessary for the proper and efficient administration of the plan;

"(4) contain (A) provisions relating to the establishment and maintenance of personnel standards, including provisions relating to the tenure, selection, appointment, and qualification of personnel, and (B) provisions relating to the establishment and maintenance of minimum standards governing the facilities and personnel utilized in the provision of independent living rehabilitation services, but the Secretary shall exercise no authority with respect to the selection, method of selection, tenure of office, or compensation of any individual employed in accordance with such provisions;

"(5) show the plan, policies, and methods to be followed in carrying out the work under the State plan and in its administration and supervision and, in case independent living rehabilitation services cannot be provided all eligible physically handicapped individuals who apply for such services, show the order to be followed in selecting those to whom independent living rehabilitation services will be provided;

"(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time reasonably require to carry out his functions under this Act, and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of such reports;

"(7) provide for cooperation by the State agency with, and the utilization of the services of, the State agencies administering the State's public assistance and public health programs, and the Bureau of Old-Age and Survivors Insurance (Department of Health, Education, and Welfare) and of other Federal, State, and local public agencies providing services relating to independent living rehabilitation services.

"(b) The Secretary shall approve any plan which he finds fulfills the conditions specified in subsection (a) of this section which is submitted as an addition to a State plan for vocational rehabilitation approved by the Secretary under title I of this Act.

"(c) Whenever the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this section, finds that—

"(1) the plan has been so changed that it no longer complies with the requirements of subsection (a) of this section; or

"(2) in the administration of the plan there is a failure to comply substantially with any such provision;
the Secretary shall notify such State agency that no further payments will be made to the State under this title until he is satisfied that there is no longer any such failure. Until he is so satisfied, the Secretary shall make no further payment to such State under this title.

"(d) If any State is dissatisfied with the Secretary's action under subsection (c) of this section, such State may appeal to the United States district court for the district where the capital of such State is located, and judicial review of such action shall be had on the record in accordance with the provisions of the Administrative Procedure Act.

"METHOD OF COMPUTING AND MAKING PAYMENTS

"SEC. 204. The method of computing and paying amounts pursuant to this title shall be as follows:

"(a) The Secretary shall, prior to the beginning of each calendar quarter or other period prescribed by him, estimate the amount to be paid to each State under the provisions of this title for such period, such estimate to be based on such records of the State and information furnished by it, and such other investigation as the Secretary may find necessary.

"(b) The Secretary shall pay, from the allotment available therefor, the amount so estimated by him for such period, reduced or increased, as the case may be, by any sum (not previously adjusted under this paragraph) by which he finds that his estimate of the amount to be paid the State for any prior period under this title was greater or less than the amount which should have been paid to the State for such prior period under this title. Such payments shall be made prior to audit or settlement by the General Accounting Office, shall be made through the disbursing facilities of the Treasury Department, and shall be made in such installments as the Secretary may determine.

"ADMINISTRATION

"SEC. 205. (a) In carrying out his duties under this Act, the Secretary shall—

"(1) make studies, investigations, demonstrations, and reports with respect to programs of independent living rehabilitation services carried on under this title;

"(2) cooperate with and render technical assistance to States in matters relating to the independent living rehabilitation of physically and mentally handicapped individuals;

"(3) provide training and instruction in technical matters relating to independent living rehabilitation services, including the establishment and maintenance of such research fellowships and traineeships, with such stipends and allowances (including travel and subsistence expenses), as he may deem necessary;

"(4) disseminate information as to the studies, investigations, demonstrations, and reports referred to in paragraph (1) and other matters relating to independent living rehabilitation services.

"(b) The Secretary is authorized to make rules and regulations governing the administration of this Act, and to delegate to any officer or employee of the United States such of his powers and duties, except the making of rules and regulations as he finds necessary in carrying out the purposes of this Act.

"DEFINITIONS

"SEC. 206. For the purpose of this title—

"(a) The term 'independent living rehabilitation services' means counseling, psychological and related services (including transportation) rendered seriously handicapped individuals and in the case of any such individual found to require financial assistance with respect thereto, after full consideration of his eligibility for any similar benefits by way of pension, compensation, and insurance, such term shall include physical restoration and related services, including corrective surgery, therapeutic treatment, and hospitalization, needed prosthetic appliances and other devices which will contribute to independent living and training in the use thereof, and maintenance needed to assure the availability of such services.

"(b) The term 'handicapped individual' means an individual of employable age, as defined by regulations of the Secretary, who is under such physical or mental disability as to require institutional care or attendance in his household continuously or for a substantial portion of the time, but who can be reasonably expected, as a result of rehabilitation services to achieve such ability of independent living that he will no longer require such institutional care or such attendance in his household.

"(c) The term 'State' includes the District of Columbia, Hawaii, Virgin Islands, Puerto Rico, and Guam.

"TITLE III—WORKSHOPS AND REHABILITATION FACILITIES

"AUTHORIZATION OF APPROPRIATIONS FOR GRANTS; PURPOSES FOR WHICH AVAILABLE

"SEC. 301. (a) For the purpose of encouraging and assisting in the establishment of public and other nonprofit workshops and rehabilitation facilities needed in rehabilitating physically and mentally handicapped individuals, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1959, the sum of \$10,000,000; for the fiscal year ending June 30, 1960, \$12,500,000; for the fiscal year ending June 30, 1961, \$15,000,000 and for each fiscal year thereafter such sums as Congress may determine for grants to carry out the purpose of this title, including any amounts which may be specifically appropriated for area facilities.

"(b) In making grants hereunder, except from funds specifically appropriated for and limited to area facilities, the Secretary of Health, Education, and Welfare, hereinafter called the Secretary, shall, insofar as practical and consistent with the purposes of this Act, distribute grants for projects in the several States in aggregate amounts proportionate to their respective populations, and in no event shall grants hereunder to a State exceed by more than 50 per centum the aggregate amount it would receive on such population basis or \$10,000, whichever is greater: *Provided*, That in any case where the Secretary of Health, Education, and Welfare finds that any State or States has no project, or insufficient projects, to utilize fully the amount it would utilize in a fiscal year, he may, after January 1 of such year redistribute the funds which would otherwise have been paid such State to other States for suitable projects and such distribution need not be proportionate to State populations.

"(c) As used in this section 'area facilities' means facilities intended to serve areas which include all or parts of two or more States.

"GRANTS FOR ESTABLISHMENT OF WORKSHOPS AND REHABILITATION FACILITIES

SEC. 302. (a) From the sums made available pursuant to section 301 of this title, the Secretary shall make grants for paying part of the costs incurred in the establishment of nonprofit workshops and rehabilitation facilities as hereafter defined and limited in subsections (b) and (c) hereof, and subject to the conditions and requirements of section 303 of this title. Such grants shall be available for payment of administrative expenses found by the Secretary to be necessary in connection with performance by the State of its functions under this title.

"(b) Nonprofit workshops and rehabilitation facilities with respect to which grants may be made pursuant to subsection (a) hereof, shall include but not be limited to—

"(1) nonprofit workshops where any manufacture or handiwork is carried on, and which are operated for the primary purpose of providing one or more of the following:

"(A) remunerative employment to severely handicapped individuals as an interim step in the rehabilitation process for those who cannot readily be absorbed in the competitive labor market, or during such time as employment opportunities for them in the competitive labor market do not exist;

"(B) an opportunity for evaluating the work potential and developing the work capacity of handicapped individuals; or

"(C) employment for handicapped individuals confined to their homes.

"(2) nonprofit rehabilitation facilities operated for the primary purpose of assisting in the rehabilitation of physically and mentally handicapped individuals—

"(A) which provide one or more of the following types of services:

"(i) testing, fitting, or training in the use of prosthetic devices;

"(ii) vocational training;

"(iii) prevocational or conditioning therapy;

"(iv) physical, occupational, or other medically supervised therapy;

"(v) adjustment training; or

"(iv) evaluation or control of special disabilities; or

"(B) through which is provided an integrated program of medical, psychological, social, and vocational evaluation and services under competent professional supervision: *Provided*, That the major portion of such evaluation and services is furnished within the facility and that all medical and related health services are prescribed by, or are under the formal supervision of, persons licensed to practice medicine or surgery in the State.

"(b) Grants shall be made with respect to construction or alteration of buildings and procurement or installation of initial equipment necessary to establish or increase their effectiveness as workshops or rehabilitation facilities, and staffing for a period not to exceed two years. Grants shall be subject to such limitations and conditions as the Secretary of Health, Education, and Welfare shall prescribe to assure minimum standards for facilities and personnel under this Act, including a system of priorities for the approval of projects.

"(c) The Federal share of cost of the workshop or rehabilitation facility established under this title shall not exceed two dollars for each one dollar which is otherwise obtained and used toward defraying such cost.

"(d) No grant shall be made under this title with respect to any workshop or rehabilitation facility unless—

"(1) application therefor in such form and containing such data and assurances as are required by the Secretary has been transmitted through and approved as feasible and necessary for vocational rehabilitation by the State agency designated pursuant to section 5(a)(1) of title I of the State where such workshop or other rehabilitation facility is located or to be located;

"(2) the Secretary finds that the facility with respect to which such grant is requested is feasible, is needed, and that Federal grants for its establishment are not available under any other Federal law;

"(3) the Secretary finds that wages paid handicapped workers meet wage and hour standards administered by the United States Department of Labor;

"(4) the Secretary requires, and the applicant provides, such assurances, in such form and with such provisions as the Secretary finds necessary to insure that the purpose of such grant will be carried out and that its conditions and limitations of such grant will be complied with.

"TITLE IV—REHABILITATION EVALUATION SERVICES

"AUTHORIZATION FOR APPROPRIATIONS

"Sec. 401. For the purpose of assisting the States in evaluating the nature and extent of the disabilities and the rehabilitation potentials of individuals of employable age, as defined in regulations of the Secretary of Health, Education, and Welfare, whose application therefor shows that they are under a substantial physical or mental handicap which may be overcome or substantially reduced by vocational rehabilitation services available under title I of this Act or otherwise available, or whose dependency may be overcome or substantially reduced by independent living rehabilitation services available under title II hereof, or otherwise available, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1959, and for each fiscal year thereafter, such sums as are necessary for grants to States to carry out the purpose of this title.

"PAYMENTS TO STATES

"SEC. 402. (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has an approved plan for vocational rehabilitation (under title I of this Act) and for independent living rehabilitation services (under title II of this Act), for each fiscal year an amount equal to two-thirds of the total of the sums expended by the State agency or agencies administering such plans during such year, including administrative costs thereof, as found necessary by the Secretary of Health, Education, and Welfare, for the proper and efficient evaluation of disabilities and rehabilitation potentials referred to in section 401.

"(b) The Secretary of Health, Education, and Welfare shall, prior to the beginning of each quarter, or such other period as he shall prescribe as appropriate, estimate the amount to be paid with respect to expenditures for such evaluations in such period, such estimate to be based on (1) a report filed by such State agency or agencies containing the estimates of such expenditures, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such period, and if such amount is less than the State's proportionate sum of such estimated expenditures, the sources from which the difference is expected to be derived, (2) records of the number of applicants for rehabilitation evaluation, and (3) such other records and reports as the Secretary may find necessary.

"(c) The Secretary of Health, Education, and Welfare shall then certify to the Secretary of the Treasury the amount so estimated by the Secretary of Health, Education, and Welfare, (A) reduced or increased, as the case may be, by any sum by which the Secretary of Health, Education, and Welfare finds that his estimate for any prior period was greater or less than the amount which should have been paid to the State under subsection (a) for such period; except that such increases or reductions shall not be made to the extent that such sums have been applied to make the amount certified for any prior period greater or less than the amount estimated by the Secretary of Health, Education, and Welfare for such prior period.

"The Secretary of the Treasury shall thereupon, through the fiscal service of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary of Health, Education, and Welfare, the amount so certified.

"(d) Payments hereunder shall not be made to a State with respect to any period for which the Secretary refuses payment of grants to such State under title I or II hereof pursuant to the provisions of such titles.

"DEFINITION OF REHABILITATION EVALUATION SERVICES

"SEC. 403. The term 'rehabilitation evaluation services' means (1) diagnostic and related services (including transportation) incidental to the determination of the nature and extent of an individual's physical and mental impairment and rehabilitation potentials and the rehabilitation services required to realize these potentials, (2) the determination of appropriate referral of such individual for vocational rehabilitation services as defined in title I of this Act, independent living rehabilitation services as defined in title II of this Act, or other needed services provided by public or private agencies. In the case of individuals found to require financial assistance with respect thereto such term also includes maintenance during any period he is required to be away from home during the period diagnostic and other evaluation services are being provided."

RESEARCH AND DEMONSTRATION PROJECTS

SEC. 5. The part of the first sentence of section 4 (a) of the Vocational Rehabilitation Act as amended by the Vocational Rehabilitation Amendments of 1954 (Public Law 565, 83d Congress, 29 U.S.C., ch. 4) which reads: "(1) For paying part of" is amended to read "(1) For paying or sharing in".

PRESIDENT'S COMMITTEE ON THE EMPLOYMENT OF THE PHYSICALLY HANDICAPPED

SEC. 6. The joint resolution entitled "Joint resolution authorizing an appropriation for the work of the President's Committee on National Employment of the Physically Handicapped Week", approved July 11, 1949 (63 Stat. 409), as amended, is amended by striking out "\$225,000" and inserting in lieu thereof "\$300,000."

[H.J. Res. 494, 86th Cong., 1st sess.]

JOINT RESOLUTION To help make available to those children in our country who are handicapped by deafness the specially trained teachers of the deaf needed to develop their abilities and to help make available to individuals suffering speech and hearing impairments those specially trained speech pathologists and audiologists needed to help them overcome their handicaps.

Whereas to meet the educational needs of some thirty thousand deaf children of school age in the United States requires the training of some five hundred teachers of the deaf annually; and

Whereas fewer than one hundred and fifty such teachers are in training this academic year; and

Whereas at least six of the institutions accredited for the training of teachers of the deaf have no trainees enrolled for the current academic year; and

Whereas while the number of deaf children enrolled in special schools or classes increased by four hundred a year over the previous ten years the increase in 1959 was more than twelve hundred; and

Whereas teachers of the deaf are needed in all States and the institutions currently accredited for the training of teachers of the deaf have the facilities for meeting the needs of all the States for such teachers; and

Whereas each State cannot and should not undertake a wasteful duplication of facilities and faculties; and

Whereas some eight million Americans of all ages suffer from speech or hearing impairments of such nature as to seriously handicap them in their efforts to become self-supporting, self-sufficient taxpaying members of their communities; and

Whereas the medical, social, emotional, educational, and rehabilitation problems of this large section of our population result from speech and hearing defects a majority of which are remediable; and

Whereas some twenty thousand speech pathologists and audiologists are needed to properly diagnose, train, and rehabilitate these eight million handicapped people; and

Whereas to meet this need there are at present in the United States only some two thousand certified speech pathologists and audiologists and some five thousand noncertified specialists in this field; and

Whereas in order to begin to cope with the problems resulting from the critical shortage of trained personnel in this field it is estimated that our universities should be graduating at least one thousand five hundred properly trained speech pathologists and audiologists each year; and

Whereas only four hundred specially trained speech pathologists and audiologists are being graduated each year; and

Whereas speech pathologists and audiologists are needed in all States to staff schools, hospitals, and community service centers; and

Whereas each State cannot and should not undertake a wasteful duplication of facilities and faculties for the training of speech pathologists and audiologists: Now, therefore, be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled,

TITLE I—TRAINING OF TEACHERS OF THE DEAF

SEC. 101. In order to encourage and facilitate the training of teachers of the deaf, the Commissioner of Education (hereinafter in this title referred to as the "Commissioner") shall, in cooperation with the Advisory Committee on the Training of Teachers of the Deaf (established by section 105 and hereinafter in this title referred to as the "Advisory Committee"), establish and conduct a program of grants-in-aid to public and nonprofit institutions which are engaged in the training of teachers of the deaf and which are affiliated with recognized public or other nonprofit institutions of higher education to assist such institutions in providing such training. Such grants-in-aid shall be used by such institutions to assist in covering the cost of courses of training and study for teachers of the deaf and for establishing and maintaining scholarships for qualified persons who desire to enroll in such courses of training and study, the stipends of any such scholarships to be determined by the Commissioner. The Commissioner shall submit all applications for grants-in-aid under this title to the Advisory Committee for its review and recommendations, and the Commissioner shall not approve any such application before he has received and studied the recommendations of the Advisory Committee with respect to such

application, unless the Advisory Committee shall have failed to submit its recommendations to him after having had adequate time to do so.

SEC. 102. Payments of grants-in-aid pursuant to this title shall be made by the Commissioner from time to time and on such conditions as he may determine, including the making of such reports as the Commissioner may determine to be necessary to carry out the provisions of this title. Such payments may be made either in advance or by way of reimbursement and shall be made only to institutions approved by the Commissioner for the training of teachers of the deaf.

SEC. 103. For the purposes of this title the term "nonprofit", as applied to an institution, means an institution owned and operated by one or more corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

SEC. 104. The Commissioner is authorized to delegate any of his functions under this title, except the making of regulations, to any officer or employee of the Office of Education.

SEC. 105. (a) There is hereby established in the Office of Education an Advisory Committee on the Training of Teachers of the Deaf. The Advisory Committee shall consist of the Commissioner, who shall be Chairman, and twelve persons appointed, without regard to the civil service laws, by the Commissioner with the approval of the Secretary of the Department of Health, Education, and Welfare. Six of such appointed members shall be individuals identified with institutions engaged in the training of teachers of the deaf; three shall be individuals identified with institutions of higher education which are affiliated with institutions engaged in the training of teachers of the deaf; and three shall be individuals representative of the lay public who have demonstrated an interest in the education of the deaf.

(b) The appointed members of the Advisory Committee shall hold office for a term of four years, except that (1) any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and (2) the terms of the members first taking office after the date of enactment of this title shall expire, as designated by the Commissioner at the time of appointment, three at the end of four years after such date, three at the end of three years after such date, three at the end of two years after such date, and three at the end of one year after such date. None of the appointed member shall be eligible for re-appointment until a year has elapsed since the end of his preceding term.

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(d) The Advisory Committee shall review all applications for grants-in-aid under this title and shall recommend to the Commissioner the approval of such applications as, in the opinion of the Advisory Committee, contribute to the carrying out of the purposes of this title, and the disapproval of such applications as, in the opinion of the Advisory Committee, do not contribute to the carrying out of such purposes.

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SEC. 106. (a) For the purpose of carrying out the provisions of this title, there are authorized to be appropriated \$1,500,000 for each of the fiscal years beginning July 1, 1959, and July 1, 1960, and such amounts as may be necessary for the eight succeeding fiscal years.

(b) The provisions of this title shall terminate on June 30, 1969.

TITLE II—TRAINING OF SPEECH PATHOLOGISTS AND AUDIOLOGISTS

SEC. 201. In order to encourage and facilitate the training of speech pathologists and audiologists, the Director of the Office of Vocational Rehabilitation (hereinafter in this title referred to as the "Director") shall, in cooperation with the Advisory Committee on Speech and Hearing Disabilities (established by section 205 and hereinafter in this title referred to as the "Advisory Committee"), establish and conduct a program of grants-in-aid to public and nonprofit institutions of higher education which are engaged in the training of speech pathologists and audiologists to assist such institutions in providing such training and in recruiting persons to receive such training. Such grants-in-aid shall be made only to institutions of higher education which have been approved by the Director as offering programs of such nature and content as to enable students who have successfully completed such programs to qualify for an advanced certificate in speech pathology or audiology from a recognized national accrediting body. Such grants-in-aid shall be used by such institutions to assist in covering the cost of courses of graduate training and study leading to the master's or doctor's degree and for establishing and maintaining graduate fellowships with such stipends as may be determined by the Director. The Director shall submit all applications for grants-in-aid under this title to the Advisory Committee for its review and recommendations, and the Director shall not approve any such application before he has received and studied the recommendations of the Advisory Committee with respect to such application, unless the Advisory Committee shall have failed to submit its recommendations to him after having had adequate time to do so.

SEC. 202. Payments of grants-in-aid pursuant to this title may be made by the Director from time to time, in advance or by way of reimbursement, on such conditions as the Director may determine, including the making of such reports as the Director may determine to be necessary to carry out the provisions of this title. Such payments shall be made only to institutions approved for the training of speech pathologists or audiologists by the Director.

SEC. 203. For the purposes of this title the term "nonprofit", as applied to an institution of higher education, means an institution owned and operated by one or more corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

SEC. 204. The Director is authorized to delegate any of his functions under this title, except the making of regulations, to any officer or employee of the Office of Vocational Rehabilitation.

SEC. 205. (a) There is hereby established in the Office of Vocational Rehabilitation an Advisory Committee on Speech and Hearing Disabilities. The Advisory Committee shall consist of the Director, who shall be Chairman, and twelve persons, appointed without regard to the civil-service laws, by the Director with the approval of the Secretary of the Department of Health, Education, and Welfare. Six of such appointed members shall be individuals who devote a major part of their efforts to departments of speech pathology and audiology in institutions of higher education and who shall be chosen so as to reflect varied specialties represented in such departments, three shall be individuals chosen from the ranks of professional people actively engaged in the diagnosis, training, or rehabilitation of individuals suffering serious speech or hearing impairments, and three shall be individuals representative of the lay public who have demonstrated an interest in the problem of speech and hearing disabilities.

(b) The appointed members of the Advisory Committee shall hold office for a term of four years, except that (1) any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and (2) the terms of the members first taking office after the date of enactment of this title shall expire, as designated by the Director at the time of appointment, three at the end of four years after such date, three at the end of three years after such date, three at the end of two years after such date, and three at the end of one year after such date. None of the appointed members shall be eligible for reappointment until a year has elapsed since the end of his preceding term.

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mining the extent to which such program is succeeding in carrying out the purposes for which it was established. On the basis of such reviews the Advisory Committee shall submit to the Director such recommendations with respect to the operation and administration of the program as it may deem advisable, together with any recommendations for legislation which it may deem necessary or desirable to carry out the purposes for which this title was enacted. Such recommendations, together with the Director's comments thereon, shall be referred to the Secretary of Health, Education, and Welfare for transmittal by him to the Congress.

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(e) The Director may utilize the services of any member or members of the Advisory Committee in connection with matters relating to the provisions of this title, for such periods, in addition to conference periods, as he may determine.

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SEC. 206. (a) For the purpose of carrying out the provisions of this title, there are authorized to be appropriated \$2,000,000 for each of the fiscal years beginning July 1, 1959, and July 1, 1960, and such amounts as may be necessary for the eight succeeding fiscal years.

(b) The provisions of this title shall terminate on June 30, 1969.

[H.J. Res. 488, 86th Cong., 1st sess.]

JOINT RESOLUTION To help make available to those children in our country who are handicapped by deafness the specially trained teachers of the deaf needed to develop their abilities and to help make available to individuals suffering speech and hearing impairments those specially trained speech pathologists and audiologists needed to help them overcome their handicaps

Whereas to meet the educational needs of some thirty thousand deaf children of school age in the United States requires the training of some five hundred teachers of the deaf annually; and

Whereas fewer than one hundred and fifty such teachers are in training this academic year; and

Whereas at least six of the institutions accredited for the training of teachers of the deaf have no trainees enrolled for the current academic year; and

Whereas, while the number of deaf children enrolled in special schools or classes increased by four hundred a year over the previous ten years, the increase in 1959 was more than twelve hundred; and

Whereas teachers of the deaf are needed in all States, and the institutions currently accredited for the training of teachers of the deaf have the facilities for meeting the needs of all the States for such teachers; and

Whereas each State cannot and should not undertake a wasteful duplication of facilities and faculties; and

Whereas some eight million Americans of all ages suffer from speech or hearing impairments of such nature as to seriously handicap them in their efforts to become self-supporting, self-sufficient taxpaying members of their communities; and

Whereas the medical, social, emotional, educational, and rehabilitation problems of this large section of our population result from speech and hearing defects a majority of which are remediable; and

Whereas some twenty thousand speech pathologists and audiologists are needed to properly diagnose, train, and rehabilitate these eight million handicapped people; and

Whereas to meet this need there are at present in the United States only some two thousand certified speech pathologists and audiologists and some five thousand noncertified specialists in this field; and

Whereas in order to begin to cope with the problems resulting from the critical shortage of trained personnel in this field it is estimated that our universities should be graduating at least one thousand five hundred properly trained speech pathologists and audiologists each year; and

Whereas only four hundred specially trained speech pathologists and audiologists are being graduated each year; and

Whereas speech pathologists and audiologists are needed in all States to staff schools, hospitals, and community service centers; and

Whereas, each State cannot and should not undertake a wasteful duplication of facilities and faculties for the training of speech pathologists and audiologists: Now, therefore, be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled,

TITLE I—TRAINING OF TEACHERS OF THE DEAF

SEC. 101. In order to encourage and facilitate the training of teachers of the deaf, the Commissioner of Education (hereinafter in this title referred to as the "Commissioner") shall, in cooperation with the Advisory Committee on the Training of Teachers of the Deaf (established by section 105 and hereinafter in this title referred to as the "Advisory Committee"), establish and conduct a program of grants-in-aid to public and nonprofit institutions which are engaged in the training of teachers of the deaf and which are affiliated with recognized public or other nonprofit institutions of higher education to assist such institutions in providing such training. Such grants-in-aid shall be used by such institutions to assist in covering the cost of courses of training and study for teachers of the deaf and for establishing and maintaining scholarships for qualified persons who desire to enroll in such courses of training and study, the stipends of any such scholarships to be determined by the Commissioner. The Commissioner shall submit all applications for grants-in-aid under this title to the Advisory Committee for its review and recommendations, and the Commissioner shall not approve any such application before he has received and studied the recommendations of the Advisory Committee with respect to such application, unless the Advisory Committee shall have failed to submit its recommendations to him after having had adequate time to do so.

SEC. 102. Payments of grants-in-aid pursuant to this title shall be made by the Commissioner from time to time and on such conditions as he may determine, including the making of such reports as the Commissioner may determine to be necessary to carry out the provisions of this title. Such payments may be made either in advance or by way of reimbursement and shall be made only to institutions approved by the Commissioner for the training of teachers of the deaf.

SEC. 103. For the purposes of this title the term "nonprofit", as applied to an institution, means an institution owned and operated by one or more corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

SEC. 104. The Commissioner is authorized to delegate any of his functions under this title, except the making of regulations, to any officer or employee of the Office of Education.

SEC. 105. (a) There is hereby established in the Office of Education an Advisory Committee on the Training of Teachers of the Deaf. The Advisory Committee shall consist of the Commissioner, who shall be Chairman, and twelve persons appointed, without regard to the civil service laws, by the Commissioner with the approval of the Secretary of the Department of Health, Education, and Welfare. Six of such appointed members shall be individuals identified with institutions engaged in the training of teachers of the deaf; three shall be individuals identified with institutions of higher education which are affiliated with institutions engaged in the training of teachers of the deaf; and three shall be individuals representative of the lay public who have demonstrated an interest in the education of the deaf.

(b) The appointed members of the Advisory Committee shall hold office for a term of four years, except that (1) any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and (2) the terms of the members first taking office after the date of enactment of this title shall expire, as designated by the Commissioner at the time of appointment, three at the end of four years after such date, three at the end of three years after such date, three at the end of two years after such date, and three at the end of one year after

such date. None of the appointed members shall be eligible for reappointment until a year has elapsed since the end of his preceding term.

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TITLE II—TRAINING OF SPEECH PATHOLOGISTS AND AUDIOLOGISTS

SEC. 201. In order to encourage and facilitate the training of speech pathologists and audiologists, the Director of the Office of Vocational Rehabilitation (hereinafter in this title referred to as the "Director") shall, in cooperation with the Advisory Committee on Speech and Hearing Disabilities (established by section 205 and hereinafter in this title referred to as the "Advisory Committee"), establish and conduct a program of grants-in-aid to public and non-profit institutions of higher education which are engaged in the training of speech pathologists and audiologists to assist such institutions in providing such training and in recruiting persons to receive such training. Such grants-in-aid shall be made only to institutions of higher education which have been approved by the Director as offering programs of such nature and content as to enable students who have successfully completed such programs to qualify for an advanced certificate in speech pathology or audiology from a recognized national accrediting body. Such grants-in-aid shall be used by such institutions to assist in covering the cost of courses of graduate training and study leading to the master's or doctor's degree and for establishing and maintaining graduate fellowships with such stipends as may be determined by the Director. The Director shall submit all applications for grants-in-aid under this title to the Advisory Committee for its review and recommendations, and the Director shall not approve any such application before he has received and studied the recommendations of the Advisory Committee with respect to such application, unless the Advisory Committee shall have failed to submit its recommendations to him after having had adequate time to do so.

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MR. ELLIOTT. Our first witness today is the gentleman from New York, Mr. Lindsay, in whose congressional district these hearings are being held.

**STATEMENT OF HON. JOHN V. LINDSAY, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF NEW YORK**

Mr. LINDSAY. Mr. Chairman and members of the committee, first of all, I should like to thank you, Mr. Chairman, for your courtesy to me in inviting me to sit with you on these hearings on as important a subject as this. I think you have done a great service, and the members of the subcommittee, not only in undertaking this study but in coming to New York City to hold hearings on the subject.

In this city, as I am sure you are aware, this subject is of paramount importance. In fact, nothing that I can think of domestically at the moment is of such great concern to people as a whole. Obviously, the Federal Government cannot undertake to cure all of the ills of the Nation from the top to the bottom, every age level, and of every kind and description, but clearly there is a Federal responsibility in certain defined areas where it has been proven that the local communities cannot possibly cope with the total situation.

Let me, in just the very few brief moments that I have, initially record my enthusiasm for your bill, Mr. Chairman, House Joint Resolution 494, which undertakes to provide a modest, and I would think minimum, degree of Federal responsibility for the training of teachers, specialists, that is, in the area of total deafness.

This is increasingly a national problem. Medical science has been able to bring about conditions under which mothers give birth to children where, decades ago, the children probably might not have lived. There are increasing medical problems, obviously, sometimes caused by this.

To me it is not logical to say that the National Defense Education Act, which is now in effect and which provides Federal assistance on a matching basis for the teaching of professional people in the areas of languages and sciences, where there have been such demonstrated shortages, to say that that same kind of thinking and philosophy should not extend also to other areas where there is demonstrated need, and demonstrated need particularly for experts in a highly technical educational sense, of a very high degree of professional capacity.

Just let me point out one area on this subject. The Lexington School for the Deaf, which occupies a leadership position in this whole field, is located just 20 or 30 blocks uptown on 68th Street and Lexington Avenue. The Lexington School for the Deaf really is a leader in this field. They do not take children unless they are totally deaf.

The subcommittee should realize, first of all, that in that particular school there is no charge for tuition for the children. It is a private school, but it operates largely on State assistance. However, here is the problem: All of the technical aids in the world, such as electronic equipment and that kind of thing, is necessary, and we must have it, and it is obtainable, but none of that is any good unless you have high-caliber skilled teachers.

At the Lexington School for the Deaf they have student teachers in residence from all over the country who are being trained for this specialized service. But do you realize that they have to pay a tuition for the privilege of being educated technically so that they can go on and spend the rest of their lives devoted in this field?

It is expensive to live in New York. At least, they have rooms at the Lexington School for the Deaf so that these teachers can be housed. But their tuition fee must be paid by them in toto. Then, of course, you must realize also that they already have their B.A. degree and in a great many cases their M.A. or Ph. D. degrees.

So here they go on for specialized training in this all-important field where, believe me, you and I would be astonished, I am sure, to see the things that they do with these deaf children. Then they go on, and in the city of New York, for example, they become teachers, teaching for the deaf, and yet their salaries are less than the average public-school teacher in the city of New York, and their qualifications must be twice as high.

So if there is a need for Federal assistance in the area of languages and sciences, where the shortages have been already demonstrated, then certainly here is an area of increasing importance, as modern science grows, where the Federal Government, I think, has some responsibility.

I am happy to note that I received a letter from the Department of Health, Education, and Welfare the other day on this subject. First of all, let me say that the Department was most enthusiastic about the cooperation they had been receiving from you, Mr. Chairman, in this whole area.

With regard to their thinking on the subject of this particular bill, the assistance to the teacher training of the deaf, they state:

The Department's position has not progressed to the point where we can definitely outline the extent to which we can support such measures. However, there is strong feeling within the Department that this is not only a worthy but also a necessary program.

I have just one word on the second most important bill—it certainly isn't second in importance, but it is the second I want to mention—your bill, Mr. Chairman, H.R. 3465, on independent living. Here, again, is an area of huge importance.

As I sit in my congressional office here in the city of New York and constituents come in with their problems, of high priority among the problems that do come in is the area of people who are chronically disabled, but who do not come under one of the great assistance areas, such as foundation assistance.

There was one the other day, for example, whose daughter had been totally paralyzed from the neck down, but no specialist could diagnose it as a polio case. Therefore, she did not come under the assistance program that the Polio Foundation is ready to give. Doctors would like to have diagnosed it as polio, but they could not do it.

This particular constituent said:

I am not asking for anything for myself. I need full-time help for this child. I need special teachers. I can afford to pay for it, but I have become increasingly interested in the problem.

One thing it seems to me that a congressional examination could do would be to see whether there are any means by which some of these huge voluntary foundations, for example, engaged in programs such as polio and heart, could be encouraged to expand their activities to take into account the undiagnosed problems.

Other people have the same problem as I do, and there are literally thousands of them in New York City, and obviously cannot afford the kind of thing I can afford.

I was happy to note also in the letter that I received from the Department of Health, Education, and Welfare, from the Acting Assistant Secretary in charge of legislation, that on your bill, Mr. Chairman, on this subject of independent living, that the Department "favors the approach taken in these bills and is considering additional suggested legislation in the general area of independent living."

I am very happy to see that this continual working relationship has existed between the subcommittee and the Department of Health, Education, and Welfare. Again I congratulate you, Mr. Chairman, and the members of the subcommittee, for having had the courage and taking the time to examine this subject with the thoroughness that you obviously are examining it.

Thank you very much.

Mr. ELLIOTT. Thank you, Congressman Lindsay. We are happy to be in your Congressional District and we are happy to hear you.

Our next witness today is Mr. M. E. Freelund, executive director, National Organization for Mentally Ill Children, Inc.

Mr. Freelund, you may proceed in accordance with our understanding that we must do our best to hold our witnesses within the period of about 10 minutes.

STATEMENT OF M. E. FREELUND, EXECUTIVE DIRECTOR, NATIONAL ORGANIZATION FOR MENTALLY ILL CHILDREN, INC.

Mr. FREELUND. Thank you very much, Mr. Chairman, and members of your committee, for the opportunity to appear.

As you know from the name of our organization, I speak in behalf of the mentally ill children of this country.

Mr. ELLIOTT. Mr. Freelund, before you get started, do you have a written statement for the record?

Mr. FREELUND. Unhappily, not yet. I have it just in rough form. I would like permission from the Chair to submit this sometime during the day, if I may, or tomorrow, while the hearing is in session.

Mr. ELLIOTT. Without objection, the statement of Mr. Freelund will be included when submitted to the subcommittee.

Mr. FREELUND. Thank you.

I will first address myself to the initial area outlined by your committee and speak of urgent needs in special education and rehabilitation for these children. Such a question sincerely posed sharply points up the tragic plight of the Nation's mentally ill children, estimated to number about half a million, perhaps the largest single group among the country's most neglected handicapped and afflicted children, for not only is there virtually a total lack of special educational services and facilities, and programs of rehabilitation for these children, there is also in literally no community in the country any adequate and effective service available for their care and treatment.

In connection with the upcoming 1960 White House Conference on Children and Youth, my organization has prepared a report which summarizes the total problem of childhood mental illness and states the role of the national organization, and poses some question in the general area of unmet needs, apart from those specifically delineated by this committee.

With the permission of the Chair and the members of the committee, I should like to submit this for the record or for the perusal of the committee, as it deems appropriate.

Mr. ELLIOTT. The statement of the gentleman will be received and will be made a part of the files of the subcommittee.

Mr. FREELUND. It is, of course, our purpose and intention to collaborate and work very closely with the study under the auspices of this committee.

In a country so responsive to the needs of the afflicted, how do we explain our neglect of this large group of handicapped children? We are told that the problem has been recognized for only a relatively short time. It is only in the last 20 years, for example, that childhood schizophrenia and infantile autism have been diagnosed. Psychiatric care is expensive and we still have insufficient knowledge concerning the causes and cure of mental illness. However, enough work has been done by responsible professional investigators to justify setting up constructive programs and continuing research.

Parents of seriously disturbed children did not organize until rather recently to seek help for their children because the fear of stigma made them reluctant to identify themselves as the parents of mentally ill children. Since mental illness is neither fatal nor physically crippling, it is difficult to mobilize public support.

The family of the mentally ill child, unlike that of other handicapped children, finds little understanding or help in the community. Instead of the spontaneous assistance offered to the physically handicapped, their child is treated with fear and apprehension. The child's illness is baffling and the parents are often burdened with a crushing sense of guilt or responsibility for the illness.

Fortunately, a large body of psychiatric opinion does not hold the parents or the environment solely responsible and is helping to relieve one source of great anxiety from these families.

For example, Dr. Loretta Bender has written:

We have not found that these emotionally disturbed, atypically developed, schizophrenic children come from any special type or home of parents; they come equally from homes of intelligent, sophisticated, economically secure parents and from the unintelligent, naive, and underprivileged. They come from concerned, cooperative, two-parent families, and from grossly deviate, antisocial, abandoning parents. Some parents have grown emotionally in their efforts to meet their children's needs and are articulate about their problems. Other parents have met failure with depression and psychotic breakdowns.

We believe—

goes on Dr. Bender stating her own opinion—

that no child will become schizophrenic regardless of the type of home situation or the care he received as an infant unless he has been born with this inherent factor. However, it is certainly true that the kinds of home life and personal care during infancy will very much influence the way the child reacts to his inborn tendency to illness.

Finding help for the mentally ill child is a discouraging and often demoralizing search. Diagnostic terms are confusing and not reassuring. Prognosis for the same child will range from the extreme of complete hopelessness to the optimism of "he will outgrow it."

Yet in many instances, the development of the child refutes either. Private psychiatric treatment is too expensive for most families and clinical facilities are usually available for children with better prog-

nosis. This is a bitter reality for the parent to accept, since we have been lead to believe that the more serious the illness, the more urgent the need for treatment.

From an administrative and budgetary point of view, it is no doubt logical to take those cases with better prognosis. Yet in the case of seriously disturbed children, mentally ill children, have we enough objective information to know certainly which will improve?

On the subject of prognosis, Dr. Bender has written, and I cite this particularly to the attention of your committee in connection with your concern about education and special education for these children. Dr. Bender has written:

Our longitudinal studies showed that one-third of the children had remained so withdrawn or disturbed that they never were able to get along in a normal school or social situation. One-third were part of the time in partial adjustment. The best one-third were able at least part of the time to get along quite well in a limited school or social situation. A few have done very well indeed in high school, college, military service, or supporting themselves. Of course, both they and their parents have needed a great deal of support and guidance and many changes in treatment programs.

Most public schools exclude the seriously disturbed child. Private schools are costly. The effect of this frustration in finding help creates growing tension in the family. This anxiety inevitably is communicated to the troubled child.

If there are brothers and sisters in the family, they will be caught in this chain reaction as they become aware of the family tension, the attitude of neighbors, and the constant demands made on their parents by the sick child.

We must provide an educational program which will help the community accept the mentally ill child as a sick child, and assume responsibility for his care.

Another reason advanced for the failure to embark on a comprehensive program of help for the mentally ill child is the lack of specific knowledge on the incidence of mental illness in children. Never has any definitive study been made, but enough is known, of course, to demonstrate that the need is far greater than the facilities.

I am pleased to state before this committee that the Biometrics Division of the U.S. Department of Health, Education, and Welfare has begun to work with our organization on a systematic compilation of statistical data in a meaningful way that will yield much information, not only about incidence itself, but about needs and about programs and the whole range of data that will be very useful in dealing with this problem. I am pleased to say that they are cooperating with us in this effort.

I am mindful of the time and I do not want to overrun. But I would like to sum up this part of my comment by saying that our organization, since its inception some 10 years ago, has sponsored private day schools, maintained at great cost and under constant threat of abandonment because of the difficulty of financing, where we have shown and demonstrated beyond any doubt that these children in the right kind of educational setting can be helped, that their very disabilities can provide, their very apprehensions, their very anxieties can provide, the bridge to academic learning. They have learned to read. Those who are autistic and noncommunicating have learned to speak.

The problem in special education in these children is to reach them first and then to teach them. As you are well aware, this kind of specialized setting is hard to come by.

I should just like to point out the specifics now in summing up of the needs in special education. We need institutions dedicated to the training and development of teaching personnel, where today they have no specialized curriculum related to the training of teachers who work with mentally handicapped or mentally ill children.

This kind of curriculum that has yet to be developed should include educational methodology and content as well as courses in normal childhood development and psychopathology in children. Further, it should include orientation and preparation for cooperative work with allied disciplines, such as psychiatry, psychology, social work, pediatrics, and neurology.

Graduate training of this kind should further include supervised fieldwork or supervised training in specific facilities that are directly working with mentally ill children.

We suggest further that there is great need that any facility that renders direct services to mentally ill children on a day or in-patient business needs to provide on-going supervision and in-service training to such teachers, making them part of the working team of experts.

There is considerable variation and looseness in the amount and kind of in-service training now taking place in facilities rendering direct treatment and educational services to mentally ill children.

In the field of rehabilitation, which is also within the area of concern of this subcommittee, we feel the needs are raising of standards in care, treatment, and education of mentally ill children in State hospitals, with special attention to mentally ill adolescents, providing them with vocational guidance and training.

We feel there is need for provision of halfway houses or transitional day treatment facilities for children ready for discharge from in-patient facilities, where these halfway houses are charged with responsibility of accepting State hospital patients.

We need also ancillary or helping services to child and family, to protect previous therapeutic investment and to maximize the child's ability to assume a limited though productive role in society. These must include sheltered workshops, protected employment, a full-scale educational program to convince industry to accept mentally ill people in employment, and social and psychological services for child and family to support and enable the child or young adult to take and maintain his place.

I suggest a particularly urgent and cogent reason for the enactment of specific legislation to support the training of leadership personnel in this field. In recent months, we have seen, for example, in New York State, the enactment of the Speino bill, which for the first time authorizes local school boards to make special provision for special educational facilities adapted to mentally ill and emotionally disturbed children.

In New Jersey, they have enacted the Beidelsen bill, patterned after this. Pennsylvania is considering similar legislation. I suggest to the committee that this legislation, if enacted and as enacted, remains sterile and meaningless unless there be implementation of it. It is a proper role, I submit, for the Federal Government to stimulate and

encourage not only the enactment of such State legislation, but also its effective implementation.

Specifically, then, we suggest that it is the responsibility of the Federal Government to provide special training programs for the professional preparation of leadership personnel in the education of emotionally handicapped and mentally ill children. This can be done through fellowship programs and/or providing leadership through those installations involved in the training of teachers, whereby a comprehensive national program for training of leadership personnel for education in this specialized area is undertaken in every State in the Union.

The committee is well aware of the recent passage and enactment of Public Law 85-926, which authorizes the allocation of 150 graduate fellowships to the 50 State educational agencies and 14 universities, in a move to increase the number of leaders in the education of mentally retarded children.

We urge that a public law be written and enacted that would be uniquely and especially geared to the public assumption of responsibility for the training of educational leaders in the field of emotionally handicapped and mentally ill children.

Mr. Chairman, I hope I have not overstayed my time. I had much more to say which I will incorporate in my written statement. I submit to your committee that the proposed legislation under consideration now for the benefit of the deaf and for the benefit of the blind, I believe it is, we heartily endorse.

We would like to see such legislation enacted for all handicapped children. We are in favor also of your bill, Mr. Chairman, for living assistance.

Mr. ELLIOTT. Thank you very much.

Our next witness is Mr. R. A. Loberfeld, executive vice president of the New York City Cancer Committee of the American Cancer Society, Inc.

Mr. Loberfeld, will you come forward, please?

Is Mr. Loberfeld here?

If not, our next witness is Mr. William H. Bristow, director, New York City Board of Education, Bureau of Curriculum Research.

Is Mr. Bristow here?

If not, our next witness is Miss Helen Holodnak. Miss Holodnak comes to us from the rehabilitation service, Kings County Chapter, Inc., of the National Multiple Sclerosis Society.

STATEMENT OF MISS HELEN B. HOLODNAC, KINGS COUNTY CHAPTER, NATIONAL MULTIPLE SCLEROSIS SOCIETY, BROOKLYN, N.Y.

Miss HOLODNAC. May I make an amendment to my representation? I am representing the National Multiple Sclerosis Society and the Kings County Chapter of the National Multiple Sclerosis Society.

Mr. ELLIOTT. You may proceed, Miss Holodnak.

Miss HOLODNAC. Recently the U.S. Public Health Service issued a bulletin to the press indicating that 10 percent, or about 17 million Americans, are limited in their ability to work, keep house, or pursue outdoor activities.

About 4,859,000 of this number have difficulty in moving about or require assistance in moving about. It was estimated that of these, approximately 1 million are completely confined to their homes.

In the light of this statement, the provisions for the severely disabled of the proposed bill, H.R. 3465, or the "Rehabilitation Act of 1959," have great significance both socially and economically. At the present time, the State rehabilitation agencies provide evaluation services for those who apply for vocational rehabilitation with the ultimate goal of placement in the competitive labor market.

Those individuals who are not eligible for vocational rehabilitation programs or who cannot achieve vocational rehabilitation are excluded from the benefits of present legislation. The proposed legislation fills in gaps in legislation pertaining to rehabilitation, thereby making it possible for States to improve and broaden the scope of services to include the severely handicapped who can benefit from rehabilitation services, but who may not necessarily be able to achieve vocational rehabilitation.

Therefore, it is readily apparent how important this legislation is for those who fall in the group who are chronically ill, particularly for the group we represent—the multiple sclerotic.

In the area of chronic illness, multiple sclerosis is a major medical problem. Dr. Thomas M. Rivers said that multiple sclerosis is the foremost neurological problem of our time. Multiple sclerosis is a chronic, usually progressive and crippling neurological disease striking chiefly persons in the 20 to 40 age group.

There is a significantly higher prevalence in the North than in the South, a finding also true in Europe. It appears that slightly more women than men are afflicted. There is no difference found between ethnic, occupational, social, or economic groups, nor between rural and urban populations. The disease is typically slow and insidious in onset, frequently difficult to diagnose until symptoms have progressed to the point of extensive disability.

There is no specific diagnostic test for multiple sclerosis, the cause is unknown and no treatment of the many which have been tried and are being tried has been shown to alter the course of the disease. Occasionally there are unexplained instances of prolonged remission from the disease and usually individuals resume their normal activities.

Dr. H. Houston Merritt states that multiple sclerosis is the greatest cause of chronic disability among young adults. It is estimated that there are 500,000 persons in the United States who are afflicted with multiple sclerosis and related demyelinating diseases. It is interesting to note that two-thirds to three-fourths of the cases have their onset between the ages of 20 to 40—the employable years—and that 1 in 400 young adults in this age group has multiple sclerosis or a related demyelinating disease.

The incidence of disease is less in the second and fifth decade, and there is a small percentage of cases found before the age of 10 and after the age of 50. The life expectancy of a multiple sclerotic approaches that of the average person, although he suffers from varying degrees of disability and is more susceptible to respiratory disorders and intercurrent infections.

Since in the early stages of the disease the symptoms are usually mild and transient, a substantial percentage of multiple sclerotics work for a period of many years in their professions or chosen areas of work. However, for many, the point is reached where the disease has encroached upon their coordination and dexterity so that they can no longer continue in their chosen work.

The needs of this group, at present, are being met in part by the State rehabilitation agencies for those individuals who are found to be capable of vocational rehabilitation and competitive employment. The rigid policy of accepting only those who can physically tolerate an 8-hour working day in competitive employment has deprived many of the opportunity for vocational rehabilitation and retraining and of employment on a part-time basis, commensurate with the individual's work tolerance.

Consideration should be given to the group who can benefit by vocational rehabilitation services but whose work tolerance is less than the traditional 8-hour day. Very often, in this group, the multiple sclerotic cannot travel in subways and buses at the height of the rush hour, but can manage quite adequately if he leaves a little after the morning rush, and starts home a little before the homeward rush.

Then there is the group who have been found not feasible for vocational rehabilitation, but for whom a prevocational or conditioning therapy program has been recommended, in order to ascertain whether or not there is a rehabilitation potential.

Unfortunately, even in the large metropolitan area of New York, facilities are very limited, and such a recommendation often results in a closure of the case. There is a need for more nonprofit rehabilitation facilities which would provide prevocational and conditioning therapy as well as other services.

For the severely disabled, the sheltered workshop offers opportunity for employment and for a measure of economic independence. One of the functions of a sheltered workshop is to foster and develop the skills and work capacity of the client to the point where he can make the transition to competitive employment. But for a substantial percentage of the chronically ill, the sheltered workshop will provide an opportunity for employment for the more severely disabled who cannot make the transition to competitive employment.

Sheltered workshop facilities are needed even in large metropolitan areas where some exist to provide opportunities for employment for the severely disabled. The chronically ill who are homebound constitute a residue of manpower for whom extremely limited facilities for employment exist.

In a substantial percentage of multiple sclerotics, paralysis has limited ambulation to a few steps or has resulted in confinement to a wheelchair. Also restricted to their homes are those whose ability to manage physically is adequate, but who have developed symptoms of incontinence which preclude employment in the competitive labor market or in a sheltered workshop.

For those who are confined to their homes for years, there is an urgent need for employment opportunities not only for the therapeutic aspect of employment, but for the economic aspect as well. Since an individual cannot qualify for disability benefits under social security until he is 50 years of age—providing he has met the necessary requirements—there is often a period of years of economic stress.

Usually the spouse must seek employment and the family lives marginally, or the family qualifies for some form of financial assistance from an appropriate Government agency.

The development of employment opportunities for the homebound is an area which requires special emphasis and implementation. It is noteworthy that statistically the number of women stricken by multiple sclerosis and demyelinating diseases is slightly greater than for men. The preponderant majority of women are housewives, and many of them are in need of vocational rehabilitation services to enable them to function adequately as homemakers.

The importance of providing independent living rehabilitation services to the severely disabled cannot be overemphasized. It is in the public's interest and in the interest of our economy to provide the severely disabled with the opportunity to achieve a state of independent living commensurate with their capacities.

Some of the severely disabled will become gainfully employed taxpayers. Some of those who are institutionalized in hospitals for the chronically ill or in nursing homes may be able to return to their homes or will require less assistance from attendants if they remain.

For those who are at home who can benefit, the provision of independent rehabilitation services will alleviate the financial strain upon families who have to purchase attendant care as well as the physical strain experienced by families in caring for the severely disabled day by day.

Dr. Thomas L. Willmon, medical and research director of the National Multiple Sclerosis Society, states:

The problem posed by multiple sclerosis is twofold: It involves a large population; its cause is unknown; its course is unpredictable; and no specific treatment has yet been found. The problem is believed soluble and progress is being made in the scientific laboratories of the world.

While there is pressing need to complete the required research and reach the problem's solution, an immediate and overwhelming need is the care and management of the patients suffering the disabilities of multiple sclerosis. The magnitude of the problem far exceeds the present ability or potential of the National Multiple Sclerosis Society, and if requirements are to be met in this and other problem of the chronically ill, the aid of the collective people of the Nation through State and/or Federal provisions must be enlisted.

Thank you very much.

Mr. ELLIOTT. Thank you very much. Are there any questions?

The gentleman from New York has a question.

Mr. LINDSAY. Can you state how much is raised annually by the National MS Society and how much is contributed toward this problem by the States? Do you know those figures?

Miss HOLODNAK. Offhand I can't give you the exact amount raised by the national society. It is several million. I cannot give you the exact figure. I can state that last year, the last fiscal year, approximately \$300,000 of the funds raised went for the support of medical research.

According to the charter which each chapter obtains from the national society, 40 percent of all the funds raised by each chapter, which is autonomous in its government, is given to the national society for the conducting of our national program and for the support of our medical research. Sixty percent remains in each local chapter for the conducting of the chapter's business and for patient services.

No State agency or Federal agency, to my knowledge, makes a direct contribution for services for the patients except where, by legal provision, certain benefits can be given. For example, in the vocational rehabilitation program, restoration, physical restoration, and transportation, and prosthesis, et cetera, except in that setting I know of no support for the direct care and service of the multiple sclerotic and, of course, for those who fall in the same category.

I would like to go on record as stating that I believe that this proposed bill, H.R. 3465, which I fondly call the Elliott bill, I believe that it is one of the most progressive pieces of legislation relating to the rehabilitation needs of our citizens that has seen the light of day.

I consider it an honor and a privilege to behold those who are serving on this committee and those who are vitally interested in this bill. I can assure you that every multiple sclerotic in the country is praying real hard day by day that this goes through next year.

Mr. ELLIOTT. Thank you very much.

Are there any other questions?

At this point the record will carry the statement of the Honorable John E. Fogarty, U.S. Representative from the Second Congressional District of Rhode Island, with respect to his bill, House Joint Resolution 316, House Joint Resolution 488, the speech and hearing bill.

(The statement referred to follows:)

STATEMENT OF HON. JOHN E. FOGARTY, U.S. REPRESENTATIVE OF THE SECOND CONGRESSIONAL DISTRICT OF RHODE ISLAND

Mr. Chairman, I am indeed pleased to have the opportunity to appear as a witness at these hearings and to discuss the proposed legislation reflected in House Joint Resolution 316 and the subsequent proposal, House Joint Resolution 488, both of which I have cosponsored with our good friend, Senator Lister Hill.

Most of my colleagues in the House of Representatives are aware of my deep personal interest in matters affecting the public health.

For the last 12 of my 18 years in Congress I have been active on the Health Subcommittee on Appropriations, either as chairman or as ranking member of the minority.

During this time I have taken great pride in the part I have been privileged to play in the establishment of broad, forward-looking programs of research in the medical and biological sciences. These programs, focusing on the major crippling diseases that chronically afflict mankind, as you know are supported and conducted by the National Institutes of Health of the Public Health Service.

Now it is my pleasure to speak in behalf of a similar program in a related area I believe is worthy of this subcommittee's most serious consideration.

I refer to the legislation before you. It proposes the creation of a system of grants-in-aid in support of the recruitment and training of teachers of the deaf, speech pathologists, and audiologists. Why is legislation of this kind necessary? Is there truly an urgent need for it?

I would like to describe the problem to you, briefly.

About one-twentieth of our population—some 8 million or more persons of all ages—is afflicted with hearing and associated speech disorders.

These impairments are not only a source of constant personal embarrassment to the sufferer, they also represent a terrible handicap to the individual in his efforts to achieve a normal, self-supporting status in the community.

The sad part is that the great majority of these people, if given the chance, are fully capable of learning how to develop their other abilities. All they need to attain their rightful places in society is the proper professional help. Therein lies the problem.

And the problem is this: Our supply of teachers and specialists trained and qualified to work in the field of speech and hearing therapy is totally inadequate. Lack of sufficient people trained to do the work is preventing the rehabilitation of a large segment of our handicapped but useful work force. The cost in wasted lives is, of course, immeasurable.

Moreover, the burden on the taxpayer who must pay to support the deaf and those with impaired speech in institutions is intolerable. Let me present some figures to illustrate the point.

Today we have 30,000 deaf children of school age. Each year this total increases. A merely adequate student-teacher ratio calls for 500 new teachers each year, but fewer than 150 are being trained this year. Of the institutions accredited for training of teachers of the deaf, six do not have a single student enrolled.

For persons suffering from speech defects, fully 20,000 speech pathologists and audiologists are needed. Yet, today there are only 2,000 of these professionals certified as having successfully completed advanced training. Another 5,000 bear the label "uncertified" specialists. Although there is an acute need for 1,500 speech therapists annually, barely 400 are graduated each year.

All of this paints a sombre picture, especially where the children are concerned. In stark terms, scarcely more than one child in five who needs speech or hearing therapy is getting it.

All of this paints a somber picture, especially where the children are concerned. to one section or region of the country. It is nationwide in extent. Although many of the States have special programs for rehabilitation and training of people with speech and hearing defects, they are unable to cope with the total problem. The problem that exists today is a clear-cut example of the type that should be attacked by having the Federal Government assume an appropriate share of the burden. The proposed legislation will do this.

The Federal Government has very effective treatment and rehabilitation programs for the deaf and hard of hearing for members of the Armed Forces and for veterans. The medical services of the Army and Navy and Veterans' Administration have made rapid advances in caring for the deaf, the hard of hearing, and those suffering from associated speech defects. The success of these programs automatically raised the question: What is being done to meet the needs of the Nation's schoolchildren, its aged, and the members of its work force in their most productive years?

Congress must act in this matter. We can be excused, perhaps, along with the average citizen, for not having faced this issue until now. Disorders of this kind are simply not dramatic enough to command attention in the way that certain of the chronic illnesses have.

But here and now we have a marvelous opportunity to perform a great good by investing a minimum amount of money in a field where dividends and bonuses are sure to be paid again and again.

We know that deafness and speech defects can be dealt with on a training and rehabilitation level. The point I want to make is that we must do all we can to see that more and more young people are encouraged to take an interest in the field of speech therapy and the teaching of the deaf.

The present bill is intended to resolve some of these manpower training difficulties. Let us see what exactly are the provisions of the bill.

First, it calls for the creation of a grants-in-aid program to be administered by the Commissioner of the Office of Education. These grants will be awarded to accredited public and nonprofit institutions in support of training for teachers of the deaf. These grants may be used by the institutions to assist in recruiting and training teachers, covering the cost of training and study, and for establishing and maintaining scholarships.

The grant applications will be considered by an advisory board of 12, established in the Office of Education. The members of the Advisory Board will be appointed by the Commissioner of Education with the approval of the Secretary of Health, Education, and Welfare. Incidentally, this follows the review and approval pattern that has functioned so well in the Public Health Service support of research and research training for the past several years.

Second, to aid in filling the need for more speech pathologists and audiologists, and to diagnose, train, and rehabilitate those with speech and hearing defects, the bill provides for grants-in-aid to assist public and other nonprofit institutions of higher education in recruiting and training speech pathologists and audiologists.

Similarly, grants provided under this phase of the program must be reviewed and recommended by an advisory committee of 12, established in the Office of Vocational Rehabilitation. The proposed legislation incorporates requirements that assure a high caliber of trained personnel. For example, only approved institutions of higher learning which qualify their graduates for an advanced

certificate in speech pathology or audiology from a recognized national accrediting body will be given grants.

These grants may be used by such institutions to help defray the cost of courses of graduate training and study and for establishing and maintaining graduate fellowships.

What harvest of benefits do I visualize from this scattered seed?

Mr. Chairman, I am reminded of an earlier day, some 15 years past, that marked the beginning of a mighty surge forward in the field of health research.

Those of us who witnessed the impressive start made by the National Institutes of Health soon realized that if it was going to maintain stride and keep from losing pace, we would have to take the necessary steps to assure a proper balance—on a national scale—between support of medical and biological research and an adequate pool of trained manpower with the capacity for conceiving and exploring research ideas.

Progress in expanding the support of research—even at the comparatively low levels of the late forties—had outstripped the development of trained manpower; the next step was clearly marked. Expanded programs in support of research were not the entire answer. We needed broad new programs in support of training to cope with the rapidly widening demand for research manpower.

Alerted to this new need, the American people promptly urged appropriate action by the Congress. The results achieved by the Public Health Service through the research training programs administered at NIH have emerged as an important facet in the progress of medical research in the 20th century.

It seems wholly logical, therefore, to propose that we take advantage of past success to achieve future goals. Let us put to use the theme of maintaining balance between the basic elements of speech and hearing rehabilitation programs in the same pattern that was applied to the whole field of medical research over 10 years ago.

Today, our knowledge of hearings and speech disorders is far greater than our capacities for applying that knowledge through adequately trained personnel. We cannot begin to apply our research findings on a clinical basis until the number of professionally trained teachers and speech pathologists and audiologists has been multiplied substantially.

If we are to help salvage any part of the 8 million persons afflicted with deafness and speech impairments, we must strive to balance our efforts by matching manpower strength with research potentials.

The ultimate effect of a large-scale program such as this one can perhaps best be measured in terms of its impact on the individual. The total impact of an expanded program in speech and hearing rehabilitation can be evaluated in terms of the individual and multiplied 8 million times to obtain the sum of the national effort:

The middle-aged survivor of a stroke who faces many months of patient and enlightened professional care to overcome his aphasia;

The mother who hears the first sounds of speech from her deaf child;

A group of young students receiving special instruction and experiencing new achievements as a result of new-found communications skills;

The industrial worker back on the job, able to do his job effectively and safely; and

The alert teenager who, short weeks ago, was labeled a delinquent until her surliness was traced to a congenital ear defect.

In years to come, I am confident that the record will show that favorable action by this subcommittee and the Congress on this legislation was not only an investment in an untapped reservoir of manpower but a priceless investment in human welfare as well.

Mr. ELLIOTT. Has Mr. Loberfeld, Mr. Bristow or Mr. Bluestein arrived?

If not, our next witness will be Mr. J. F. Phelan, Jr., executive director of the Children's Village, Inc.

Mr. Phelan, we have quite a number of witnesses. If you will summarize your statement, then the entire statement will be made a part of the record following your summary. If you can do that in 6 or 7 minutes, I will appreciate it, and that will give us a little time to ask questions.

You may proceed.

**STATEMENT OF JOSEPH F. PHELAN, JR., EXECUTIVE DIRECTOR,
THE CHILDREN'S VILLAGE, DOBBS FERRY, N.Y.**

Mr. PHELAN. Thank you, Mr. Chairman and members of the committee.

As the executive director of one of the oldest and largest treatment institutions in the country dealing with disturbed children who are both delinquent and predelinquent, I deem it a privilege to be permitted to testify before this committee.

Essentially, the institution that I represent has had a great deal of experience in working with delinquent youngsters. There have been over 55,000 children who have gone through our program in the last 109 years. The institution has also made contributions to both the State and national organizations, particularly in the field of child welfare, and in the field of special education.

Our particular interest at the present time is in special education for disturbed and delinquent youngsters, and our experiences to date indicate that we need a great deal more help from the Federal Government and from the State governments, particularly in this area of delinquency.

If I were to point out to you very, very briefly the efforts which are being made in this one particular program, I would summarize it by saying that most of the youngsters that we currently have in our program, 300 boys between the ages of 10 and 17, 90 percent of them have average intelligence and the mean age of all of these youngsters is 14 years.

Fifty percent of these delinquent and disturbed children are reading on a fifth-grade level or below, and 70 percent of these children are retarded in grade placement by 2 or more years. Sixty percent of the boys cannot achieve in arithmetic beyond the second-grade level.

This gives you some of the characteristics of the youngsters we are working with. Our problem at the present time, and it is no different in this organization or in other agencies dealing with the problem of disturbed children, is the absence of trained teachers who are capable and able to work with the kinds of problems which these children present.

Most of my comments on the experience of our agency are incorporated in my statement. However, I would like to make my recommendations to the members of the committee based on the experience of the Children's Village and other agencies engaged in this field.

First of all, we would like to recommend that provisions be made by the Federal Government to provide grant-in-aid to institutions of higher education and private training centers to provide specialized training programs for capable teachers, supplemented by on-the-job training in order to prepare qualified personnel to teach disturbed children.

Such grants-in-aid should be a joint undertaking, with the U.S. Department of Health, Education, and Welfare, and under the supervision and control of the Children's Bureau.

Second, we would like to recommend that research moneys be provided by the Federal Government, perhaps on a matching basis, to those States willing to study the problems of this area of education. These moneys should be administered on the State level to those insti-

tutions, agencies, and school districts capable of establishing demonstration and research projects in this field.

Third, we would like to recommend that the term "special education" be expanded to include "emotionally handicapped child" in its eligible categories so that any Federal assistance which would include not only physically handicapped and mentally retarded would bring about an impact on other areas of exceptional children.

Fourth, we would like to recommend that the Federal Government, through the Department of Health, Education, and Welfare, undertake a study of existing Federal legislation regarding child labor regulations and establish criteria for the employment of these children under certain conditions and when certified by public agencies.

One of the problems that we have at the present time in placing some of these disturbed and delinquent children back in the community is the already existing child labor legislation, which is aimed at protecting the average child but does not really meet the needs of the disturbed and delinquent youngster. This would serve as a guide to State legislatures throughout the country.

Fifth, we would like to recommend that provisions be made to grant Federal assistance to States on a matching basis for the development of more adequate programs of trade preparation and vocational training for special education categories of youngsters leaving institutions and schools for employment in the community.

This would include federally sponsored programs of vocational rehabilitation, which should be open to emotionally disturbed adolescents. I think the experience of the Children's Village and throughout the country has indicated that there is a terrific waste of manpower with these youngsters who could very certainly be involved in gainful employment.

Sixth, provision should be made for the allocation of Federal funds to the various States for the purpose of establishing research and demonstration projects aimed at early detection and diagnosis of problem children involving special facilities.

One final recommendation we would like to make includes development of criteria for teachers of disturbed and delinquent children. This criteria is already incorporated in the prepared statement.

Mr. Chairman, I hope I have summarized as briefly as possible.

Mr. ELLIOTT. You have cooperated very beautifully and I thank you.

The Chairman recognizes the gentleman from New Jersey for a question.

Mr. DANIELS. Mr. Phelan, in your study of this problem, are there sufficient institutions, colleges, universities, in existence in our country for the training of the necessary personnel for the disturbed and handicapped children?

Mr. PHELAN. Yes, sir. I feel that we have sufficient institutions of higher education throughout the country that could develop curriculum training for specialized teachers of disturbed children. In addition, we have not too many, but we have some training centers, treatment centers, for disturbed children where teachers could have the kind of on-the-job experience in working with these youngsters.

Mr. DANIELS. You say we have. Do you know how many of these schools or colleges have undertaken to train personnel at the present time and how many are in attendance?

Mr. PHELAN. At the present time, I would be unable to state the exact number, but in New York City we do have special education programs in some of our universities, in which graduate students are involved in studying the problems of disturbed children.

The problem, however, in the educational field, is that there is at the present time no specified curriculum of training for such graduate students. I think the recommendations that we are making here include a recommended criteria for such curriculum based on the experience of working with these disturbed youngsters.

Mr. DANIELS. Thank you.

Mr. ELLIOTT. Mr. Giaimo of Connecticut.

Mr. GIAIMO. You speak of disturbed and delinquent children. Are you restricting your definition of disturbed to include an element of delinquency in it?

Mr. PHELAN. My statement is based on the fact that legally the classification of delinquent is determined by an adjudication in a court. From a treatment standpoint, we see no difference, in my own experience, between a disturbed child and a delinquent child. He is equally disturbed.

Mr. GIAIMO. But I was wondering in your recommendations for this particular group of children whether you were speaking primarily of those groups which have an element of delinquency, or the entire field of emotionally disturbed children, whether or not there exist delinquent motivations.

Mr. PHELAN. I was referring to the entire field of emotionally disturbed children, emotionally handicapped children.

Mr. GIAIMO. Thank you.

Mr. ELLIOTT. Thank you very much, Mr. Phelan.

(Mr. Phelan's complete statement follows:)

STATEMENT BY JOSEPH F. PHELAN, JR., EXECUTIVE DIRECTOR, THE CHILDREN'S VILLAGE, DOBBS FERRY, N.Y.

Mr. Chairman and members of the committee, as the executive director of one of the oldest and largest treatment institutions in the country dealing with disturbed children who are delinquent or predelinquent, I deem it a privilege to be permitted to testify before this committee. The Children's Village has been in existence for 109 years, and during this time has exercised leadership in the child welfare and educational fields by providing care for over 55,000 boys between the ages of 10 and 17 years, in training professional staffs, and in conducting basic research in children's problems. Through its membership in national and State organizations, it has shared its experiences, contributing to the better understandings of the nature, treatment, and education of disturbed children. Within the past 3 years efforts have been made to reevaluate the special educational needs of its youngsters and to assess their experiences after they are returned to their home communities. A study in 1956 indicated that 78 percent of the boys who returned to public schools were making a satisfactory adjustment. Approximately 75 percent of the youngsters under care come from New York City, while the remaining 25 percent of the youngsters are sent to us from other counties in New York State, as well as seven surrounding States.

EXPERIENCE OF EDUCATIONAL PROGRAM

Because of the character and nature of the population served at the Children's Village, the problems of education take on a special significance for purposes of this committee. Out of a current population of 300 boys, varying in age from 10 to 17, 90 percent of them have average intelligence, and the mean age is 14 years, but 50 percent read on a fifth-grade level or below; 70 percent are retarded in grade placement by 2 or more years; 60 percent of the boys cannot achieve in arithmetic beyond the second grade level. Most have chronic truant

records and have been expelled from community schools. The history of our children is characterized by the absence of any sound familial experience. The attitude they have toward adults is often hostile, apprehensive, distrustful, and sometimes contemptible. It is apparent to us that a special education program must be geared around the adults who work with these children, who must not only be thoroughly trained in educational techniques, but must possess understanding of psychosocial factors and their implication for educational progress. Those adults must be free from the need for retaliation, have the resiliency to bounce back from trying experiences, be resourceful, and perhaps most important: they must be fascinated by these children and the challenge they present. Experience indicates that the educational needs of these children require intensive planning on an individual basis. Clinical study and research have taught us that a variety of factors contribute to the learning difficulties of disturbed children, and that the approach to these problems cannot be left to the classroom teacher alone. For example, we have been somewhat successful in marshaling a staff of trained specialists to work with these youngsters on a team basis. In addition to the trained staff of 33 certified teachers, there are available a paid staff of 249 people, including psychiatrists, psychologists, trained social workers, recreation specialists, child-care personnel, chaplains, and medical personnel, along with a corps of 300 volunteers assisting the teachers to carry out their basic functions of educating these youngsters. We have further learned that the techniques and skills required in working with disturbed children may vary considerably from the usual methods employed in community schools. A principal condition for any educational program is the pupil's motivation and desire to learn. With most of our youngsters, this ingredient is conspicuous by its absence. Subject matter and curriculum for these youngsters may be entirely dependent upon the appropriateness of the relationship which the teacher is able to establish with individual children and the climate created for the group in the classroom.

Our experience further indicates that the problems of management and supervision of a classroom is directly affected by the quality of these relationships. In a sense, this is no different than the experience with so-called average children in community schools. The difference, however, rests in the fact that most teachers can sensitively and intuitively respond appropriately to most children; that most adults can understand the motivation of most children without specialized study; that the spontaneous response of most adults to most children is right and respectful of their needs; that most schoolchildren have matured sufficiently so that they may be members of a class group. All children need understanding, and most can be understood by the normal well-intentioned adults. This is not the experience with our boys, and for that reason the clinical professions are needed to study the child, not only for clinical treatment but to bring understanding to teachers so that they may relate to these children in a manner which facilitates learning to occur, which enables the healthy aspiration which is not entwined by the emotional disturbance to function and to achieve. This has implication for the training of teachers and for the administration of the educational program.

Classroom sizes at the Children's Village average 12 youngsters, with some classes as small as 7 and others as large as 18 boys. Other aspects of the Village's special education program make provision for trained educational supervisors who are available to assist and support members of the teaching staff in their daily classroom activities. These supervisors provide a basic ingredient in supporting the classroom teacher and helping her to arrive at not only an educational diagnosis of the youngster's needs but an assessment of the youngster's total personality which is essential and critical in developing motivation for learning with disturbed children. Aside from the school principal and two educational supervisors, we have a plan to expand this to four supervisors next year, a ratio of one supervisor to every six or seven teachers.

There is no existing official field of special education with recognizable training, standards, licensing for teachers of the emotionally disturbed. Recruitment of staff is, therefore, a more severe problem than for the fields which have some tradition and recognition. Whatever training is provided comes from in-service supervision, seminars, and workshops. There is a need to establish the existence of teaching the emotionally disturbed as a profession in education. I am most pleased that this committee has made provision for spokesmen working with disturbed children to share their experiences.

Along with the study of the academic program in our agency has been an evaluation of the prevocational needs of these children in preparing them for

community employment. Our experience in placing of the older boy, between 16 and 17 years of age, in employment upon his return to the community has not been consistent with his educational growth in the Village. During the past year (1958-59), 39 boys were placed in jobs in New York City. This was the result of the efforts of a trained specialist on our staff who works as a job placement and guidance counselor with boys leaving the institution. The problem of job placement has always been a difficult one from two standpoints. First, the reluctance of employers to take on an institutional youngster in gainful employment. Secondly, the process of preparing a youngster while in the institution for a particular trade placement is hampered by child-labor legislation aimed at protecting the average normal child, but not suited to the employment needs of children who fit into the category of delinquent and disturbed children with determined potential for learning and production. Union regulations regarding age in many situations prevent adolescents from developing apprenticeships and training. Unfortunately, too few employers have recognized the value of vocational on-the-job training, and many consider this to be a waste of time since the youngsters are subject to military service. They fail to recognize the potential of these youngsters to continue their trade training while in the service and to provide a resource of manpower to the employer upon his discharge.

CONCLUSIONS AND RECOMMENDATIONS

In consideration of the foregoing, as well as the task of this subcommittee, we would like to present the following proposals based on the experience of the Children's Village in the field of special education for disturbed children:

1. Provisions should be made by the Federal Government to provide grants-in-aid to institutions of higher education and private training centers, to provide specialized training programs for capable teachers, supplemented by on-the-job training in order to prepare qualified personnel to teach disturbed children. Such grants-in-aid should be a joint undertaking with the U.S. Department of Health, Education, and Welfare and under the supervision and control of the Children's Bureau.

2. Research moneys should be provided by the Federal Government, perhaps on a matching basis to those States willing to study the problems of this area of education. These moneys should be administered on the State level to those institutions, agencies, and school districts capable of establishing demonstration and research projects in this field.

3. The term "special education" should be expanded to include the "emotionally handicapped child" in its eligible categories so that any Federal assistance would include not only the physically handicapped and mentally retarded, but bring about an impact on other areas of exceptional children.

4. The Federal Government, through the Department of Health, Education, and Welfare, should undertake a study of existing Federal legislation regarding child-labor regulations and establish criteria for employment of these children under certain conditions and when certified by a public agency. This would serve as a guide to State legislatures. Contracts of financial assistance should be established to the effect that Federal appropriations for assistance would be contingent on meeting the definitions of this legislation.

5. Provisions should be made to grant Federal assistance to States on a matching basis for the development of more adequate programs of trade preparation and vocational training for special education categories of youngsters leaving institutions and schools for employment in the community. This would include federally sponsored programs of vocational rehabilitation which should be open to emotionally disturbed adolescents.

6. Provisions should be made for the allocations of Federal funds to the various States for the purposes of establishing research and demonstration projects aimed at early detection and diagnosis of problem children requiring special education facilities.

The predominant needs as experienced by the Children's Village and other agencies involved in this problem is the acute shortage of qualified teachers, the lack of interest on the part of the public with the needs of children falling within this category, and, more precisely, the absence of a specified curriculum of training for such personnel. As an additional recommendation, we would suggest the establishment of a pilot project, perhaps under the direction of the Department of Health, Education, and Welfare and assisted by the National

Education Association to be conducted in a few of our institutions of higher education. Such a curriculum of training might include the following subject matter supplemented by field work experience at a recognized school or institution involved in the problems of special education :

1. Psychiatric concepts about human behavior ;
2. Psychological understandings of learning disabilities and their relationship to emotional problems ;
3. Group work concepts concerning the dynamics of group and peer leadership ;
4. An understanding of the functions of community facilities available for disturbed and delinquent children ;
5. Training in the use of concrete and creative nonverbal media, such as crafts, arts, music, visual aids, dramatics, etc. ;
6. A 1-year educational field placement under supervision in a recognized treatment center for disturbed children. For supervisors and administrators additional courses in the process of supervision should be provided, based on experiences in those schools which conduct pilot educational programs for disturbed children.

The problems of special education for disturbed and delinquent children present complex and challenging tasks. Techniques and developments in the field of education have not kept pace with this growing problem. Unless the Federal Government and others interested in education provide adequately for these youngsters now, they will become the occupants of prisons and State hospitals tomorrow.

Mr. ELLIOTT. Our next witness is Dr. R. H. Manheimer, medical director, Arthritis & Rheumatism Foundation, Inc.

Do you have a written statement ?

**STATEMENT OF DR. R. H. MANHEIMER, MEDICAL DIRECTOR,
ARTHRITIS & RHEUMATISM FOUNDATION, INC.**

Dr. MANHEIMER. Yes ; I do.

Mr. ELLIOTT. Will you summarize it, please, in about 6 or 7 minutes and let us ask you questions ?

Dr. MANHEIMER. Yes, Mr. Chairman.

Mr. Chairman, I am honored to appear here today, and hope that my statement will be useful to the Subcommittee on Special Education.

I shall confine my remarks to two aspects of the rehabilitation of arthritis patients, vocational rehabilitation and the rehabilitation of the homebound.

Arthritis, as you know, is a widespread chronic disease which often disables and cripples. It affects 10 million Americans, with more than 32,000 otherwise able persons rendered unemployable for an entire year by arthritis and other rheumatic diseases.

The need for vocational rehabilitation, therefore, is evident. To continue earning, many disabled arthritics must change the kind of work they do. This requires skilled help, particularly for the patient who is 40 or older. Each year we estimate it costs \$125 million in taxes to provide subsistence allowances for arthritics who cannot work.

To get as many of these men and women back to work as possible, therefore, makes good sense. We believe that the subcommittee should be prepared to encourage vocational rehabilitation activities in view of the results obtained by recent programs.

For 6 years the New York Chapter of the Arthritis & Rheumatism Foundation has been providing vocational rehabilitation for unemployed arthritis victims. This back-to-work program is run jointly by the foundation and the Institute for the Crippled and Disabled, one of the country's leading rehabilitation centers.

Each year 40 percent of the patients who enter this program do go back to work. They get jobs in regular business and industry, working side by side with nonhandicapped employees. To date, 200 men and women, some of whom had been out of work for 20 years because of disabling arthritis, have jobs which they perform efficiently despite their arthritis and without injury to their health.

To find out whether these handicapped people could sustain employment, we got in touch with 99 who had been placed on jobs at least 6 months earlier. Sixty-nine percent of these 99 persons were still working. Many had gotten wage increases; some had been working for over 2 years since their vocational rehabilitation. Not all these people gave us full information about their earnings, but 28 reported wages since they went back to work which totaled, over the 3-year period, \$79,000, more than twice what the project had cost the Arthritis Foundation up to that time.

Instead of subsisting on welfare, these men and women have become taxpayers and were contributing to the cost of running their city and country. We therefore believe that vocational rehabilitation of the unemployed arthritic is practical, realistic, and good economics.

The money spent brings concrete returns. It appeared necessary to demonstrate that not only can vocational rehabilitation for arthritics be provided in a large center like New York, but that effective services can also be devised for our widespread and growing suburban communities.

The Arthritis & Rheumatism Foundation, with the cooperation of the Long Island Jewish Hospital, and a generous 3-year grant from the Office of Vocational Rehabilitation, recently started a vocational program on Long Island to serve not only arthritis patients, but all community residents with orthopedic handicaps which now keep them from working.

This new program, unlike the back-to-work project, does not depend on the existence of a large, specialized rehabilitation center. Rather, it is located in and uses the resources of a good general hospital, such as many communities throughout the Nation also have.

Although the project is barely a year old, it also presents good evidence that a community's hospital facilities are well adapted to providing the varied services required in vocational rehabilitation. Already a number of patients have been retrained and placed on appropriate jobs in their home communities, and the number of patients coming to the project for help has been significantly larger than our original estimate.

MR. ELLIOTT. Dr. Manheimer, let me ask you this question: Has much progress been made in eradicating the pain from arthritis? Do the people that you speak of who are rehabilitated sufficiently to go back to their jobs remain free of pain as they go back to work? Have we gotten that far yet?

DR. MANHEIMER. They are reasonably free. Those who have a great deal of pain are not in condition to go back to work. Most of the patients whom we deal with, actually, are under medical treatment and require constant medical treatment. Yet they are able to get back to work. This has been our experience.

In most cases they have had to had some changes in their previous experience with work. They have had to learn a new kind of job. At times it only had to be to modification of their previous job.

For about 50 percent of those we got back to work, they had to learn a new trade altogether. The opportunities of developing a vocational rehabilitation center that can train and test these people in new jobs that they didn't consider that they had any capacity for or didn't have any comprehension about is what makes this kind of a program desirable and practicable.

Mr. ELLIOTT. Is cortisone still one of the main medications?

Dr. MANHEIMER. Cortisone, as such, is really rarely used today, but many advances have been made in cortisone derivatives so that there are now many drugs which are much less toxic than cortisone and which are really useful.

That doesn't mean that every doctor must not be aware of the cautions in using the drug. There is not a journal of rheumatic diseases that does not come out emphasizing the dangers inherent in this drug. But really, I believe it, as with many drugs, has a very useful place.

In our experience, we find that at least an important percentage of the patients who go back to work are able to go back to work, in part, at least, because they are on drugs such as the cortisone and its derivatives.

Mr. ELLIOTT. Thank you.

Dr. MANHEIMER. We are convinced that programs like this one can and should be encouraged throughout the United States so that patients afflicted with arthritis and other handicapping conditions may return to self-respect and self-support.

In analyzing how such metropolitan and suburban programs may be developed throughout our country, it would appear that Federal support would be of material help. I would like to touch on this and on how such help would be most useful in just a moment. Meantime, there is another group of arthritics equally in need of help. These are the men and women who are confined to their chairs or beds by their rheumatic disease.

A measure of the scale of this problem is the fact that of all the beneficiaries under the Federal program of aid to the permanently and totally disabled, one-tenth require such aid because of arthritis.

In 1956, 258,279 persons in the United States were receiving such aid. No one knows how many other arthritics not receiving care under the APTD are, nevertheless, confined to bed or chair, nor how many family members who would otherwise be able to earn must stay at home all day to care for them.

It has been the experience of the Arthritis Foundation that the homebound arthritic can also be helped significantly. To reach the homebound arthritic, the Arthritis and Rheumatism Foundation turned to the visiting and public health nurses who are already going into the homes of many patients too handicapped to get to doctors' offices or to clinics.

We submit that the visiting-nurse organizations are ripe and eager to assume some of the responsibility for making homebound patients more self-sufficient, more capable of the ordinary activities of everyday life. With appropriate help and encouragement, the visiting nurses are in an ideal position to do this. As evidence of what can be done, I offer the Arthritis Foundation's 3-year experience in cooperation with the District Nursing Association and the Westchester

Public Health Department. To their joint nursing staffs we added a full-time physical therapist and regular consultations with the physicians specializing in rehabilitation.

This cooperative program cared for over 120 patients. Some were bedfast, some chairbound. Others could walk, but were limited in other ways, in washing themselves or doing simple household activities. On careful analysis of the 120 case records, we found that 80 patients had improved significantly in their capacity to perform ordinary everyday activities.

This 66-percent improvement is all the more striking when I add that most of these patients were at least 60 years old and many had two or more serious diseases. Some of these 80 patients learned how to wash and dress, to shift from bed to chair, or to feed themselves without the help of another person. Some began to go out of doors or to do light household chores. In a few cases the improvement was such that a family member could go to work, thus improving the family's economic situation.

The cost per patient was about \$99, which seemed reasonable. How can the Federal Government aid in developing effective programs of home and vocational rehabilitation programs throughout this country? Two aspects of the programs I have described merit special consideration by your subcommittee:

First, both programs use existing—and I repeat, existing—highly skilled agencies to develop new rehabilitation services to meet urgent, unmet needs. Thus, the organization of our programs were simple, their operation flexible, and their costs moderate.

In considering ways and means of improving our Nation's rehabilitation services, I suggest that the subcommittee consider the value of adapting and expanding existing agencies, already well established in their communities and, as evidenced by our experience, eager to develop new ways of serving their local communities.

Second, the vital element in both home and vocational rehabilitation proved to be the highly skilled professional workers who did the work. In vocational rehabilitation our success depended in overwhelming measure on the well-trained vocational counselor. Inherent in such personnel is the developed capacity to utilize all the resources at their command, to fully evaluate the patient's limitations and needs, to develop the residual resources, to determine the exact demand of the jobs locally available, to plan training programs suitable to the patient's capacities and the community's job resources, and to carry through until the patient is actually placed at work.

In home rehabilitation, the essential factor was the physical therapist. His skill in evaluating the extent of the patient's handicap and of his residual resources, in devising self-help devices and training the nurses to plan an appropriate role in the whole enterprise, these qualities were the heart of the program.

Well trained personnel for vocational and home rehabilitation are exceedingly scarce. Time and again arthritis programs have been delayed for months because competent personnel to staff them could not be found. The growing activity in all areas of rehabilitation, welcome though it is, places a demand for personnel on the training schools which they have been unable to meet.

If this country is to meet the need for rehabilitation, if it is to encourage home rehabilitation through the visiting nurses, if it is to stimulate the development of vocational rehabilitation in suburban communities, we must produce more well trained physical therapists and vocational counselors. Only thus can we help these agencies to broaden their responsibilities to meet the needs of these changing times.

In conclusion, although I have reported to you on the experiences confined to New York City, Long Island, and Westchester, I believe that the needs of our arthritis patients here, the methods devised for meeting these needs, and the problems encountered, are representative of the needs, methods, and problems facing all the agencies throughout this country, which are trying to maintain in 10 million American arthritics the maximum capacity for motion, self-care and self-support.

Mr. ELLIOTT. Thank you, Dr. Manheimer.

The gentleman from New York, Mr. Lindsay, has a question he would like to ask.

Mr. LINDSAY. Dr. Manheimer, how much money is raised nationally by the foundation?

Dr. MANHEIMER. I am familiar with the chapter organization, and I am not quite sure about the national. I believe it is over \$1 million, about \$1½ million.

Mr. LINDSAY. What is the chapter's?

Dr. MANHEIMER. The chapter's range is between \$500,000 and \$600,000. We have our own local program of about \$200,000, and 40 percent of our fund is committed to the national for their program, which is basically laboratory research.

Mr. LINDSAY. Does the State of New York give you any direct assistance earmarked for arthritis?

Dr. MANHEIMER. No.

Mr. LINDSAY. Thank you.

Mr. ELLIOTT. Thank you very much, Dr. Manheimer. Your statement will be very helpful to the subcommittee.

Has Mr. Loberfeld arrived?

Has Mr. Bristow arrived?

Is Mr. Bluestein present?

Is Mr. George J. Hecht, of the American Parents Committee present?

You are Dr. Clarence D. O'Connor, superintendent of the Lexington School for the Deaf; is that correct?

Mr. O'CONNOR. That is correct.

Mr. ELLIOTT. Mr. O'Connor, if you will, summarize your statement in about 6 or 7 minutes. Your full statement will be made a part of the record immediately following your oral presentation.

STATEMENT OF CLARENCE D. O'CONNOR, SUPERINTENDENT, LEXINGTON SCHOOL FOR THE DEAF, NEW YORK CITY

Mr. O'CONNOR. This is a statement from Mr. George J. Hecht, who was also asked to be a witness, publisher of Parents magazine, and chairman of the American Parents Committee, Inc.

Mr. Elliott and members of the committee, the American Parents Committee, which, as you know, is an organization which works for Federal legislation for

the health, education, and welfare of the Nation's children. We are very interested in the bills before you which would stimulate and help secure specially trained teachers for the deaf and specially trained speech pathologists and audiologists for those children who suffer speech and hearing impairment. The bills which we support are the ones introduced by you, Mr. Elliott, House Joint Resolution 494 and its counterpart, House Joint Resolution 488 introduced by Mr. Fogarty.

As the witness for the American Parents Committee, I would like to present Dr. Clarence O. Connor, who is an expert in the field. Dr. O'Connor is superintendent of the Lexington School for the Deaf in New York City. He has had over three decades of experience in teaching deaf children and has engaged in active research in classroom hearing aids to facilitate such teaching. I am sure Dr. O'Connor will be a valuable witness to your committee.

Mr. ELLIOTT. We are glad to have you, Mr. O'Connor, and I am sure you are an expert in your field. You may proceed.

Mr. O'CONNOR. Mr. Elliott and members of the committee: What I have to say today is being said on behalf of Mr. George J. Hecht and the American Parents Committee, Inc., of which he is chairman, and on my own behalf as one who has been concerned with the welfare and education of the deaf for 30 years.

In addition, although I have not been requested to speak for these groups, I am confident that what I say essentially expresses the views of the following organizations working in the interests of the deaf:

The Conference of Executives of American Schools for the Deaf; the Alexander Graham Bell Association for the Deaf, of which I was president for 12 years; the Convention of American Instructors of the Deaf; the New York State Association of Educators of the Deaf; and the National Association of the Deaf.

Those for whom I speak strongly support the bill you have introduced, Mr. Elliott, House Joint Resolution 494 and its counterparts, House Joint Resolutions 488, 503, 507, 512, 516, and 526 introduced, respectively, by Congressmen Fogarty, Boland, Thornberry, Loser, Baker, and Moorhead.

These bills would provide grants-in-aid to training centers which would enable them to recruit and train professional workers for the presently seriously understaffed area of special education, the speech handicapped or impaired, and hearing impaired.

The degree of effectiveness with which one is able to communicate with one's fellow man has a profound influence on one's whole social and economic life. The reduction of the severity of a speech handicap through expert therapy, the acquisition of skill in lipreading by one who is hard of hearing, or the miracle of learning to speak by one born deaf who, because he cannot hear, would never learn to speak unless specially taught, makes it possible for those so helped to meet more equably the challenge of our competitive society, and broadens the base of their contribution as citizens.

There are millions of American children with varying degrees of speech and hearing difficulties who need the services of specially trained people to help them reach this higher level of performance. Many of these are denied this help because of the very serious shortage of trained workers in this field.

Grants-in-aid would be a powerful recruitment boost in interesting young people to enter this special field. The main factor that keeps them out is money, for special training programs are frequently superimposed on a 4-year college course. This means an extra and

uncontemplated year of expense, so the easy alternative is to enter the regular teaching field immediately after graduation.

An example of this is our experience at the Lexington School for the Deaf. We provide a teacher preparation program on the graduate level in conjunction with Teachers College, Columbia University.

For the academic year 1959-60, we received inquiries from at least 50 or 60 interested young men and women, most of whom were in their senior year in college. At least 10 and undoubtedly many more were forced to give up the idea of special training in the field of the deaf in the face of the necessity of finding up to \$2,000 to cover expenses for the year.

We could have undoubtedly had a group of 40 or 50 trainees if grants-in-aid or scholarships were at hand. Instead, we are training only 12. Some of these 12 are here, and you cannot tell from looking at them, but they have mortgaged their next several years, through borrowing, to take this special training.

Title I of House Joint Resolution 494 provides for assisting educational centers in preparing teachers of the deaf. It is generally conceded by educators dealing with all types of exceptional children that there is a more critical teacher shortage in the area of the deaf than any other field of exceptionality. A few statistics will confirm this.

In June of 1959, only 127 teachers of the deaf were graduated from the educational centers in the United States offering teacher preparation programs in this field. Over 500 were needed to supply the requirements of more than 300 school facilities in the country providing programs for deaf children.

This imbalance has prevailed for years so the cumulative effect of this is almost catastrophic. In many schools, particularly in those sections of the country with traditionally low salary schedules, educational services must, of necessity, therefore, be provided by large numbers of sincere but untrained teachers, except for what inservice training can be provided by an already overworked staff.

It is possible that in some schools as many as 75 percent of the staff might fall in this category. Financial assistance would definitely improve this most undesirable condition, and would undoubtedly make possible the establishment of regional training centers in different sections of the country which could more effectively meet the needs of each particular area.

Accompanying my statement is a bulletin published by the American Annals of the Deaf, giving detailed statistics concerning the great teacher shortage that exists in the area of the deaf.

Title II of House Joint Resolution 494 provides for financial assistance in preparing speech pathologists and audiologists. The early detection of hearing impairment is vastly important for two reasons. First, the hearing loss in many cases is reversible if discovered early enough. Second, if it is not reversible, proper educational treatment can then be provided at an early age and accordingly greater educational gains are possible.

The audiologist is the key member of the team in this process of early detection. Many more are needed than are now being trained. There are millions of children and adults in our land with speech handicaps. Some of these handicaps are the result of mild or moderate hearing impairment—these are the hard of hearing as contrasted with

the deaf. Others are caused by neurological or physical disorders. Only trained speech pathologists can properly serve this vast group. A serious shortage of trained personnel exists in this field of exceptionality.

In connection with title II, I should like to point out to the committee that probably the majority of these millions with speech handicaps are children. Accordingly, possibly the responsibility for this area of personnel training should be placed in the U.S. Office of Education rather than the Office of Vocational Rehabilitation.

I wish to thank the committee for giving me this opportunity to bring to your attention the critical nature of the shortage of trained personnel in the field of the speech handicapped and hearing impaired, and express the hope that our combined efforts to relieve this condition will be successful.

Mr. ELLIOTT. The Chair recognizes the gentleman from New Jersey.

Mr. DANIELS. Dr. O'Connor, how many children would you estimate are in the United States who are totally deaf?

Mr. O'CONNOR. Attending schools for the deaf and the programs that I mentioned, over 300 programs, there would be 24,000 or 25,000 approximately, and in the whole United States, children between the school ages of 5 to 18, perhaps, we might calculate that there would be as many as 40,000 to 50,000 really deaf children, severely deaf.

Mr. DANIELS. Are there any children that do not attend school?

Mr. O'CONNOR. Some of these youngsters attend schools for the normally hearing, are integrated with them.

Mr. DANIELS. How many of them do you think suffer from speech defects, requiring training from specialized personnel?

Mr. O'CONNOR. In the speech field, I am not as familiar with that field, but I think the figure used for all speech handicaps is 6 million, and this is the range of from 3 to those over 65. Within the speech area, this is the calculation; there would be several million that have speech defects.

Mr. DANIELS. How many accredited institutions are there in the United States for the teaching of personnel for the deaf?

Mr. O'CONNOR. Training the teachers of the deaf? I think we count 22.

Mr. DANIELS. Do you know where they are located?

Mr. O'CONNOR. They are located throughout the United States. I think they are listed in the pamphlet which has been submitted.

No, I am not sure that they are.

Mr. DANIELS. Could you obtain a list for the committee and furnish that to the committee in the next few days?

Mr. O'CONNOR. I will be glad to.

Mr. DANIELS. Do you know how many teachers there are in training at the present time?

Mr. O'CONNOR. Something in the neighborhood of 150 or 160. It is a little more this year than it was last year.

Mr. DANIELS. How many teachers would you estimate would be necessary in order to take care of our present needs and requirements?

Mr. O'CONNOR. Properly to take care of them, we should train 500 a year at least, to fill in at least the backlog of this accumulation of untrained personnel.

Mr. DANIELS. What do you estimate to be the shortage of teaching personnel for the deaf and the speech handicapped?

Mr. O'CONNOR. The speech I will have to pass to the experts in the speech field. In the field of the deaf particularly—although I know the figures they are using, they feel they should train 1,500 speech pathologists and audiologists per year, in order to catch up on the services not being rendered properly; in the area of the deaf, it is estimated that 500 a year will meet the current needs.

Mr. DANIELS. In what period of time?

Mr. O'CONNOR. 500 a year.

Mr. DANIELS. For how many years?

Mr. O'CONNOR. This would be a figure that would go on indefinitely. The replacement factor is this number.

Mr. DANIELS. If I understand your testimony correctly, there is a great shortage at the present time.

Mr. O'CONNOR. That is correct.

Mr. DANIELS. What do you estimate the shortage to be, so that the committee can formulate some opinion as to what the need may be and appropriate the necessary sum of money if we feel it should be done?

Mr. O'CONNOR. The difference between those fully trained and those needed to be fully trained is about 350. This means about 150 are being prepared, but we need 500. This would mean that 350, a differential of that number, each year, would be necessary to meet the ongoing needs. Multiply this by any number of years.

Of course, this does not provide for the replacement of those that I spoke of that are operating and untrained.

Mr. DANIELS. Thank you, Doctor.

Mr. ELLIOTT. Mr. Giaimo?

Mr. GIAIMO. No questions.

Mr. ELLIOTT. Mr. Lafore?

Mr. LAFORE. No questions.

Mr. ELLIOTT. Mr. Lindsay?

Mr. LINDSAY. It is a pleasure to listen to Dr. O'Connor's testimony. He is really one of the experts and leaders in this field.

I should like to say that if the members of this subcommittee have any time at all in their crowded schedule, I am sure Dr. O'Connor would be pleased to show the facilities and the things that they are doing in the school that he heads up, the Lexington School for the Deaf.

Mr. O'CONNOR. I will be very happy to, indeed, any time. We have our teacher training program there, and you can see what is required of young people to meet this challenge of a year's graduate study to become teachers of the deaf, and why.

Mr. ELLIOTT. How many teachers are you training at your school this year?

Mr. O'CONNOR. Twelve this year.

Mr. ELLIOTT. Are these young ladies part of the class [indicating a group attending hearing]?

Mr. O'CONNOR. These young ladies, and Father John, himself.

Mr. ELLIOTT. Where is your school located?

Mr. O'CONNOR. 68th and Lexington, New York.

Mr. ELLIOTT. Thank you very much. We have heard you with a great deal of interest. What you have said is very helpful, Dr. O'Connor.

Mr. O'CONNOR. Thank you.

Mr. ELLIOTT. May I say that the subcommittee is very happy to have with it this morning the chairman of the full Committee on Education and Labor of the U.S. House of Representatives, the Honorable Graham A. Barden, of North Carolina.

We are indeed happy to have you, Mr. Barden, and trust that you will enjoy our hearing here in New York City.

Would you care to say anything at this time?

Chairman BARDEN. Not at this point, Mr. Chairman.

Mr. ELLIOTT. Our next witness is Mr. William J. Rosengarten, director of special services, Roslyn Public Schools.

Mr. Rosengarten, will you summarize your testimony and leave the written statement with the reporter?

Mr. ROSENGARTEN. Yes, Mr. Chairman.

Mr. ELLIOTT. You may proceed.

STATEMENT OF WILLIAM J. ROSENGARTEN, DIRECTOR, SPECIAL SERVICES, ROSLYN PUBLIC SCHOOLS

Mr. ROSENGARTEN. Mr. Chairman and gentlemen, I come here not as an expert. I know that there are experts available. I come here as an educator on the local level who is facing this problem of finding proper educational placement for youngsters of various disabilities.

I am particularly anxious this morning to relate a little about the plight, if I may use the word, of a fellow like me when he is faced with a problem of placing a youngster who is labeled by the general term "emotionally disturbed" or even "brain injured."

No one has cared to define that exactly, and I am not interested, really, in the definition nor the therapy, nor the ideology, or whatever it is that the M.D.'s and other doctors do along the lines of therapy and that kind of aid. I am interested in education, the problem of educating children who come to us with these symptoms, which can be described in various medical and educational terms.

The emotionally disturbed child, who cannot benefit from education that is provided in the public schools, and when I say public schools I am referring to my own limited bailiwick—Roslyn is a relatively small suburban community on Long Island whose citizens do try, to the best of their ability, to meet the educational needs of all the youngsters, including the handicapped—the problem of the emotionally disturbed has been taken up somewhat this year by the Vocational Education and Extension Board of Nassau County, under the auspices of the State education department, in a limited way to make a start.

I have heard other witnesses plead for the training of teachers, and the development of research projects that may help. On the local level, however, I feel that the greatest benefit can come from research carried on at the local level, where the teaching needs to be done, rather than in the university classroom or laboratory classroom that can be set up in limited quantities here and there in the country.

If the Federal Government could help the States through financial aid and any other matter, by providing expert advice to offset the costs of setting up small experimental groups in the various communities where such children reside, I think we could develop some kind of

program for the emotionally disturbed or the brain injured which would result in their education, their gaining of knowledge, perhaps their ability to handle themselves in the so-called normal world.

I feel a little bit disturbed when we have to exempt youngsters from public education because they cannot benefit from what we have. While legally this exempts us from certain responsibility, I do not feel exempted morally and I would like to see something further done if we can assume this responsibility.

So my plea, then, is just one: That the Federal Government, if it can, assist the State with special moneys earmarked for experimentation on the local level in the area of the emotionally disturbed or brain injured who would ordinarily be excluded from normal public education.

Thank you.

Mr. ELLIOTT. Are there any questions of this witness?

The Chair recognizes the gentleman from North Carolina.

Chairman BARDEN. Would you go just a little further and describe the kind of setup you would want in your local community?

Mr. ROSENGARTEN. If it were possible, through the efforts of the experts, to identify a number of children who could be placed or put together as a group, rather than as a 1-to-1 therapist-patient setup—well, a group can be defined as more than one, anywhere from 2 to 5 to 10, I don't know, but I presume it would be small.

The effort made in Nassau County now is in one section a group of 5 and in other communities it gets as large as 12 or 15. If this group of children could be brought together within the age limits of compatibility as well as the compatibility of symptoms so that a teacher could work with these youngsters, regardless of what we label them, to educate them in whatever way they can benefit, whether the teacher can be provided with special methods, special curricular objectives, material, and equipment, if all this could be worked on at the local level, then I think we would have the kind of group or setup which might make a start, at least, in handling this program.

Chairman BARDEN. May I follow that by asking: Would you have that teacher with special qualifications or is that a type of mutual education, she learning the habits, the ways, and so forth of these children, and working from a practical point of view?

Mr. ROSENGARTEN. You sound as if you are an educator, too, because teachers always learn from their children, and education is mutual. It would certainly be mutual in this regard because the teacher at this time is not truly an expert, because with all the help of the other agencies that have testified here, and I am sure that will follow, it makes a difference when you are right in with the youngsters trying to accomplish something with them, to alter their behavior, to reach some educational objectives which you can see and observe, and measure in a youngster's achievement or accomplishment.

So this teacher would certainly have certain qualifications. He would have to be able to approach this problem without preconceived ideas, although he has probably been reading as much as he can, or conferring as much as he can, with the experts; a teacher who would be able, through his own personality, to understand the plight of the youngster and his parents, and who would be able to withstand a great deal of frustration, who could reorient his own life from the

traditional academic point of view to the type of curriculum involved which might be quite different from the three R's in the usual educational objectives.

A person that flexible, that devoted, that strong, to be able to withstand the problems that would arise from this sort of exercise, would be required.

Chairman BARDEN. That is all.

Mr. ELLIOTT. Are there any further questions?

If not, thank you very much, Mr. Rosengarten.

Our next witness is Mr. H. L. Tunney, secretary, Department of Corrections, State of New York.

Is Mr. Tunney here?

If not, our next witness is Dr. H. Schueler, chairman, Department of Education, Hunter College.

Dr. Schueler, you may proceed. If you possibly can, hold your presentation within 7 or 8 minutes. It will be appreciated.

STATEMENT OF DR. H. SCHUELER, CHAIRMAN, DEPARTMENT OF EDUCATION, HUNTER COLLEGE

Dr. SCHUELER. Thank you, Mr. Chairman.

I speak on behalf of the teacher education program at Hunter College, but in a sense everything I have to say applies in the same measure, although different in details, to the teacher education programs in the other three municipal colleges in the New York City municipal college system, City College, Brooklyn College, and Queens College.

All four colleges have programs in special education and rehabilitation although they specialize in different phases. There are several suggestions that I would have to make as to possible assistance that these programs could use. It is not necessarily true that all this assistance should come from the Federal Government, but there are certain areas in which we feel that we do need assistance. Let me give you some specific examples.

For example, we feel very strongly the need for a year-round demonstration center in the special education rehabilitation, that is, a type of laboratory school. We feel very strongly that future and present teachers in special education and rehabilitation need to see the immediate, practical applications of whatever work they do in the university and need to have the opportunity to see actual demonstrations and to practice with handicapped people who have special needs.

We have such a program in the summer session. We have a special demonstration center for our summer program. It has been so successful that we would like to expand it for the year around. Obviously, facilities are not available at the present time. We utilize resources that are used in the college during the year, demonstration resources in our campus schools, that are available only in the summer.

This I would put first in the need in this area for us, assistance in whatever way is possible, especially in physical facilities and specialized personnel. Such a center would be most valuable, not only as a demonstration center but, of course, also as a center for research, needed research in, for example, the area of the multiple handicapped. Such research, the experts tell me, is desperately needed.

A second area is, again, an extension of the research area. I have been told that many funds have been made available for research in

mental and medical health problems of the handicapped, but a rather limited amount has been made available for research into the methods of training and development to fruitful citizenship of the handicapped.

We are specifically interested in that area and would like to expand whatever work we have been able to do.

Another area is one of assistance to students, especially future teachers, in this area of special education and rehabilitation. We have in our graduate program a student body of approximately 250. The largest proportion of this group is in part-time attendance. These may be teachers in service who take a course or two whenever the time has come to take that course.

We have very few, or relatively few, and far fewer than desirable, full-time students who can pursue an intensive program of short duration to make them fully qualified to enter the profession of training the handicapped and those with special needs.

In order to do that, however, since there is no particular advantage, at least a monetary professional advantage, for the teacher of the special areas, we feel a very great need for fellowships, or some other type of subsistence program, to enable young people and teachers in service to spend a year with us in full-time residence in intensive study, rather than to piece out their training in the area over 4, 5, or 6 years, and perhaps even abandoning it after a while.

A third area is some assistance in the personnel of the colleges. As you undoubtedly know, the demands of this training require training in very small groups. The best analogy I can think of is in some of the more specialized laboratory sciences. To have large lecture sessions or even large seminar sessions of 30 and 35 in this area is useful up to a point, but you have to have a smaller student-teacher ratio, professor-student ratio, than is usual in most college programs.

A practical course, for example, on guidance, or one of the courses in guidance that is needed is the kind in which you have the best possible opportunity for interplay and meeting of minds with the teacher and the students. Therefore, a laboratory approach, a workshop approach of small groups, is needed.

Under our present resources which are partially tax levy, partially student fees, partially from private funds in special education, we find ourselves unable to even approach what we consider to be the optimum professor-student ratio. There we are seeking and continually seeking for ways to increase our staff, even with the student body that we now have, in order to make this training more meaningful.

Another area of need is in the area of training of supervisors, people who are at work in the schools who are trained teachers but would have to coordinate programs of multiple need. In an average school you will have, if you are lucky, a classroom for the handicapped, let us say and you have all kinds in there. Most of the teachers are not prepared in all of the areas that we would like them to be prepared.

Proper supervision is most important. We would like, for example, to establish, let us say, an intensive summer institute for personnel already engaged in working with the handicapped, but on the techniques and possibilities of the supervision of the partially trained or even the nontrained people whom they have to deal with in programs of special need in the schools and in private agencies.

An analogy would be the types of intensive institutes for the training of mathematics and science teachers that have received Federal funds. We have had those at the colleges, and City College has found them most useful. To extend that type of aid to the area of special education we would find most helpful.

We feel, even with our resources, which I know are considerable, at least for a public institution, that if we were to expand our work in a more close approximation of needs, we would have to take too large a proportion of the budget that is available, let us say, for the training of teachers of all kinds.

We train every conceivable type of teacher and supervisor in our schools. But experience has shown that the specific needs of special education require a larger proportion of such resources because of the particular problems that are involved. We feel that we have gone far enough and will not be able to go any further with our present resources, and even though we feel we are doing a good job in our programs, we are looking for assistance in various areas. The Federal Government is just one of the many.

I think that summarizes what I have to say.

Mr. ELLIOTT. The Chair recognizes the gentleman from New Jersey.

Mr. DANIELS. Dr. Schueler, were you present when the previous witness testified?

Dr. SCHUELER. Yes.

Mr. DANIELS. He recommended a teacher be engaged to teach various children suffering from handicaps, both mental and physical.

Do you think that is a good, practical proposition?

Dr. SCHUELER. It is a practical proposition, because that is the reality at the present time. The extent to which any school system can afford to establish special classes for the specially handicapped is extremely limited.

Mr. DANIELS. Are not various problems presented by virtue of the disabilities that each particular child has, and it might require some special knowledge or training?

Dr. SCHUELER. Yes.

Mr. DANIELS. Would one person be able to attend and take care of all of those special problems?

Dr. SCHUELER. In any situation even approaching the satisfactory, I would say no. Of course, it depends upon the size. You would need to section according to special needs in special areas. Of course, with unlimited resources and large numbers, you can section more closely, but, for example, the orthopedically handicapped, the deaf, the blind, the mentally retarded, and the combination of the neurologically impaired and the mentally retarded with orthopedic handicaps, which are often present, and the emotionally disturbed, each of these areas presents very special problems.

There are common things, of course. But to put them all in one room, even though it has to be done, and have one person expected to do it all, I think is tragic.

Mr. DANIELS. Therefore, it requires training of personnel to deal with each individual problem.

Dr. SCHUELER. That is right; yes, sir.

Mr. DANIELS. Thank you.

Mr. ELLIOTT. The Chair recognizes the gentleman from Connecticut.

Mr. GIAIMO. Doctor, you are speaking of existing projects and enlarging them with Federal funds; is that the idea?

Dr. SCHUELER. That is right.

Mr. GIAIMO. Can you tell me what part the States are playing in the enlargement of these projects, if any?

Dr. SCHUELER. I have no specific knowledge. I know there is some assistance gotten through the States, and through special legislation in the State of New York attempts are being made for special education. The specific nature of that I have no immediate knowledge of.

Mr. GIAIMO. What you are suggesting is that we enlarge the training of personnel and supervisors?

Dr. SCHUELER. Yes. There is obviously a need for no duplication of State and Federal effort, but a coordination of the two.

Mr. GIAIMO. That is all.

Mr. ELLIOTT. Mr. Lafore?

Mr. LAFORE. No questions.

Mr. ELLIOTT. Mr. Lindsay?

Mr. LINDSAY. No questions, Mr. Chairman.

Mr. ELLIOTT. Thank you very much, Dr. Schueler. Your testimony has been helpful and we appreciate it very much.

Our next witness is Mr. Joseph Prendergast, executive director of the National Recreation Association.

Is Mr. Prendergast present?

Miss HILL. I am representing Mr. Prendergast.

I am Beatrice Hill, director of the consultant service recreation for the ill and handicapped of the National Recreation Association.

STATEMENT OF MISS BEATRICE HILL, DIRECTOR, CONSULTANT SERVICE RECREATION FOR THE ILL AND HANDICAPPED OF THE NATIONAL RECREATION ASSOCIATION

Mr. ELLIOTT. You are appearing for Mr. Prendergast?

Miss HILL. Yes.

This is my specialty.

Mr. ELLIOTT. You may proceed.

Miss HILL. Thank you very much.

It is not my purpose here in any way to quarrel with the concept of the rehabilitation of the chronically ill and handicapped. We are all gathered here precisely because of one thing, our belief in this, the third phase of medicine, rehabilitation, and because all of us wish to contribute whatever we can toward expanding and improving this service, rehabilitation, to the severely ill and handicapped citizens of the United States.

We in the reclamation profession have no cause to question what has been done rehabilitatively for the chronically ill and handicapped. But we do question what is not being done for them, the unmet needs.

I am speaking here both of the vocationally rehabilitatable and of the supposedly nonemployable.

On the subject of who can and who cannot be gainfully employed, let me tell you the story of a very dear friend of mine, Jimmy Seaborn. The year is 1949. The boy Jimmy is 18 years old. The diag-

nosis is rheumatoid arthritis. It affected his entire spine. Vocational rehabilitation rating is zero.

Rehabilitation teams say, "Sorry, kid, we can't do a darn thing for you. You are just going to have to spend the rest of your life in a chronic hospital here in New York City." He had no family.

Today, 10 years later, Jimmy, unable to either walk or sit, is limited in movement to a slow-motion shuffle on crutches, or he gets all over the place on a self-propelled stretcher, is a full-time recreation leader at the prevailing wage scale in the St. Joseph's Home for the Aged in Peoria, Ill., 1,000 miles from Goldwater Memorial Hospital in New York City, for so many years his permanent home.

How did this come to be?

America?

No. The answer to Jimmy Seaborn and his triumph over his crippling handicap was motivation through social rehabilitation; in short, developing in him a driving need to function to the fullest degree possible within the limitations of his handicap and the knowledge and skills necessary to satisfy the need.

Ten years ago, when I first met Jimmy, he was technically on the verge of melancholia, living in one of Goldwater's 32 wards. They have 2,000 patients, with little or no contact with people beyond their own ward. He was discovered by me in one of my tours of the ward. I was recreation therapist there.

The first step in the development of James Seaborn, recreation leader, was taken. I persuaded him to join the patients' glee club. In a short while, not too many months later, Jimmy became the glee club director.

Then I talked him into becoming a reporter on the patient's newspaper. I am saying this as if it went quickly, but it didn't. It was very slow. He went on the newspaper and became the editor of the newspaper.

So it went over the years, with constant encouragement, motivation in recreation therapy and skills. He participated in dramatics, arts, crafts, the hospital intercom radio operation; in short, all the activities which make up a well-rounded program of recreation in a hospital.

Today, as I said, this boy who cannot sit in a chair as you or I, can only move with the greatest of difficulty, directs a complete recreational program for the aged. He recruits and trains volunteer aids in Peoria. He motivates the aged patients of St. Joseph's Home toward the social community which is necessary if the home is to be a community, not just a home, in the true sense of the word. They are not just there to wait for death.

This is just one example, but an extraordinary one, of the value of recreational therapy as a tool in helping to motivate the seriously handicapped to the point where whatever potential is left is susceptible to vocational rehabilitation.

It is not our claim that all persons as severely handicapped as Jimmy can develop their employment potential to the degree that he did, but there are thousands and thousands of Jimmys. We see them all the time, institutionalized and noninstitutionalized, of all ages, and they have never gotten their chance, because at the time of interview and evaluation there seemed to be no possibility of vocationally re-

habilitating them. Due to their severe disability, they had been isolated, either in the hospital or their own home.

Thus, through their lack of group contact, they had not had the opportunity to be able to learn to feel confident and to express themselves in the best possible manner. And also, perhaps, the most wonderful thing about the Jimmy story is not that he was employed 4 months ago, but rather that he was happy in the 9 years prior to that in the real community atmosphere which regularly programed recreation created in this hospital.

This brings me to the suitability of the vocationally nonemployable. What a very big subject that is, embracing several million chronically ill or handicapped people. To be very trite, a statement we all make 10 times a day, medical science has added many years to these people's lives. But what is being done to make their lives meaningful?

Take one of my pet targets, which is the nursing homes. There are 25,000, and they are only just beginning nursing homes in this country. They house 450,000 people.

In no place that I have discovered in the Hill-Burton Act is the need for recreation activities, for food for the mind as well as for the body, emphasized before any one of these nursing homes can be built.

I and my organization, the National Recreation Association, have been and are intimately concerned with the developments of recreation activities in any and all nursing homes.

Two years ago, and that is not awfully long ago, less than 1 percent of the nursing homes out of this group of 25,000 had any type, leave alone what type, of recreation activities for their old people.

As Dr. Russell says, they were given "bed and bored."

Today we are beginning to make excellent headway through a plan we developed.

I also want to say that we now have serviced over 1,000 nursing homes by the most simple thing, simply that if a home can't afford a recreation leader, which they can't—how can an 18-bed home afford one recreation leader—we get six or seven together in the area to coordinate salary and basic equipment, and then recruit and train volunteers in the community to service this home.

You would think I had made an Einstein discovery, but it was very simple. Now over a thousand homes that we have account of have recreation, and there are still 24,000 more to go.

During the course of this work in nursing homes and voluntary workers in the homes, I have had many contacts with social workers, some of them working with the Federal Government. This is what I hear over and over again: "Miss Hill, first things come first. There are so many essentials that need attention first. Food, adequate nursing care, fire hazards," and on and on.

My answer is: "Since when in our culture has the sustenance of the spirit ceased to be a basic essential to the normal living? What is the use of keeping the person alive if there is nothing to live for?"

To me, this goes hand in hand, recreation activities—whatever you want to call it—with good nursing care and fire safety. I think the Government should be very concerned in this area.

Current studies show that without meaningful activity the mind as well as the body regresses. There are about 25 studies, which I can show anyone interested, proving exactly this. Regression comes by

lack of activities in the aged. Our minds apparently do not stand still. They either go forward or backward, and without activity they go backward.

Our viewpoint is that it is important, as I said, to the nursing or care of the individual; just so important is recreation activity, social communication, food for the mind, as well as the body, and there must be legislation and it must be enforced.

These people cannot be put in these homes and left there to die.

According to the Office of Vocational Rehabilitation, there are several million chronically ill or handicapped homebound individuals in the United States. The figure I believe, is 4 million that are homebound. Fewer than 200 agencies—and most of them are the small voluntary groups, none within New York City—do anything in the way of meeting the recreational social communication needs of these shut-ins. Very, very few of these people are serviced socially.

Again, like the old people in the homes, they sit studying alone in their rooms, in their homes, homebound, day after day and year after year, staring at the windows. Nobody comes to see them, and they go to see nobody. Recreation can be brought to them, and with proper planning a great lot of these people can go to places of recreation in the community via adequate transportation.

It should be the responsibility of agencies servicing the homebound that they are not only given occupational therapy occasionally, physical medicine, social service, and housekeeping, but what about the most important thing—happiness?

Social rehabilitation must be provided, and it can be done. Any time I am asked, I can tell you. I sincerely believe that the rehabilitation team cannot fully determine the extent of the patient limitation, physical or mental, without proper evaluation of his social potential. This can only be studied in the context of social activity. Fewer than 2,000 of our 7,000 hospitals provide recreational services to their long-term chronically ill patients. The patient's ills are ably treated. His physical surroundings for the most part are comfortable. But little or nothing is being done to help him adjust to his surroundings and hospital routine, to help sustain or cultivate his morale, to contribute to the general welfare of his whole being by providing enjoyable experiences and opportunities for social expression.

There is also a dramatic need in the pure rehabilitation setting. We should have a ward in a hospital, a rehabilitation ward, or be it a clinic, for programing which will help the patient learn new social activities which accommodate his physical or mental rehabilitation. And more than just teaching him things he can do for happiness with his handicap, the department needs to go further. They need to evaluate his family and the community to which the patient is going to return and see where are the available social outlets, recreational outlets, and be sure that the patient learns of them, and doubly be sure that the patient is welcomed by the bowling alley, the hobby club, or wherever it is, wherever he can find some happiness when he returns, a rehabilitated but handicapped individual.

Another area of great need is playgrounds for children. I don't remember how many thousands of playgrounds—there were so many that I couldn't get a count for today—there are in the United States. But I had sent questionnaires around to every one of them a year ago.

It was in the thousands. I got answers from 247 playgrounds that in any way—I am not going into the quality—the handicapped child was allowed to play or provision made for him in this country.

Take your neighborhood centers around the United States, the camps, the centers for the aged, if you accept the handicapped, young or old. A statistical count of those that do is very, very small.

That the Federal Government is mindful of the importance of recreation therapy is clearly evidence by the wonderful programing which is an essential part of the total care program of every service and Veterans' Administration hospital in this country. But much further, Federal aid is needed to adequately develop this much-needed service, recreation for our ill and handicapped population, whatever their surroundings be—hospital, home, nursing home, or furnished room.

Grants are needed to do research, to properly evaluate the job to be done in recreation and how best to do it. Money is needed to develop demonstration projects in recreation for the ill and handicapped.

Finally, to develop visual material, particularly pamphlets and manuals, presenting the findings and studies of the demonstrations and studies for recreation for the ill and handicapped.

Without social communication, which is the end result of recreational therapy, there can be no independent living.

In conclusion, there is a great difference, as you all know so well, between isolation and independence. Independence means freedom and the ability to form relationships with others; dependency can be a great isolating factor. There must be a reinterpretation of rehabilitation agencies and services, and vocation must not always be the main goal. To quote a doctor friend of mine, "There is a need to make a life rather than a living."

Thank you very much. I hope I got in under 10 minutes.

Mr. ELLIOTT. Thank you, Miss Hill. Your presentation was very interesting. We appreciate it very much.

Miss HILL. Thank you.

Mr. ELLIOTT. Are there any questions?

If not, thank you very much.

May I say that Dr. Merel Frampton, who is the director of the Special Rehabilitation Study of the Subcommittee on Special Education of our committee, has a statement for the record, I believe, from some gentleman who was scheduled to testify.

Dr. FRAMPTON. Ernest E. L. Hammer, president of the Lavelle School for the Blind, could not be here today, and requested that I present this statement of his testimony to be received by your committee.

If it meets your pleasure, I would like to so present this statement and request that it be included in the record.

Mr. ELLIOTT. Without objection, the statement will be made a part of the record at this point.

(Statement referred to follows:)

MEMORANDUM SUBMITTED BY HON. ERNEST E. L. HAMMER, PRESIDENT OF LAVELLE SCHOOL FOR THE BLIND, NEW YORK CITY, N.Y.

Speaking only from my personal experience as president of Lavelle School since 1952, as a trustee since 1927, and personal contact since 1916, I am of the opinion that each and every blind and handicapped child should be given such

public aid as will place each child in a position of comparable equality with normal children.

By rough estimate, in the United States in 1951 the number of blind persons of all ages amounted to 330,000, and of that number 30,200 were under 21 years. The numbers stated for 1940 were 230,354 and under 21 years 22,400, and in 1950 the figures were 297,000 and 25,600, respectively. This indicates an increase of the under-21 group of about $12\frac{1}{2}$ percent in 10 years and about 40 percent in 16 years. This also indicates an increase of approximately $2\frac{1}{2}$ percent per year.

Mr. M. Robert Barnett, executive director of the American Foundation for the Blind, Inc., in testimony as an expert on handicaps in respect of the condition of blindness, per se, and in the relationships of the blind with the sighted in family, home, school, and in adult social life and gainful employment, referred to some significant statistics as of 1959. He stated:

"At the moment, the best estimates place the total number of blind people in the United States at about 350,000. Statisticians predict that the number will be in excess of 400,000 by 1970. About 10 percent are of school age, meaning more accurately under 21, while the most significant age breakdown is that of 65 years of age and over, into which category more than half of the total number falls. Somewhere in between are those of so-called employable age. However, the actual percentage of clearly employable people comes down markedly because of factors which complicate simple blindness."

This indicates an increase of one-seventh or about 14 percent in about 10 years. In 1956, Lavelle School had an attendance of 102. If Lavelle School attendance, which in 1956 was 102, and in 1959 was 185, merely increases at the rate of $2\frac{1}{2}$ percent per year, in 1969 we would have 231 and in 1979 about 277. However, our attendance increase in the 5 years from 1954 to 1959 was 83 in numbers and rough percentage about 16 percent per year, or the indicated additional attendance of 333 in the next 5 years. Even if this estimate were discounted by 50 percent per year, it would result in about 40 percent increase or 259 pupils in 5 years and 80 percent in 10 years; i.e., an addition of 148 or a total of 333 children in 1969. This type of thinking leads one intimately familiar with Lavelle School, its facilities, administration, management, and progress to the estimate of about 300 children in attendance in 10 years, but in no event less than 200 to 250 in the intervening years.

My personal services, and the services of the other officers and trustees, of course, are given gratuitously to Lavelle School for the Blind, the children in attendance, and the school's graduates in high schools, colleges, and in their later business and social lives and their useful participation in the activities of society. In New York State there are three so-called residential schools for the blind. They are the New York State School for the Blind at Batavia, N.Y.; the Institute for the Blind and Lavelle School for the Blind, both of the latter being in Bronx County, New York City. These schools, formerly completely residential, have become mainly day schools. This change from residential school to residence at home has occurred by reason of the change in thinking and policy of the New York State Department of Education and that of educators and sociologists in regard to the family and parents' relationship and the home and social life as more beneficial to the handicapped than residence at school.

The services rendered by the administrative staffs, the superintendents, principals, teachers, nurses, physicians, psychologists, social workers, and other assistants, as well as by the executives, trustees, and directors, undoubtedly extend out and have an influence in the general welfare of the blind and other handicapped. In a measure, therefore, that which is good for one school or institution becomes a benefit to others and is helpful for the common good.

This outspreading of benefits also undoubtedly helps in the education and attitudes of the public generally in respect of the blind and the otherwise handicapped. It also, I believe, tends to relieve or reduce psychosocial, organic, physiological, and other medically known factors which may disturb the blind and the handicapped and prevents mental blocks or attitudes rendering it difficult for the handicapped child and sometimes even the adult to make normal use of existing capacities and abilities. Behaviorisms resulting from mental disturbance sometimes cause animosities, resentments, and retaliatory acts on the part of the handicapped or the other normal person in particular association or transaction and consequent unfair judgment or action on one side or the other.

The law of the State of New York (art. 89, secs. 4401, 4402, et seq.) defines "a physical handicapped child" as a person under the age of 21 years, who by reason of a physical defect or infirmity, whether congenital or acquired by accident, injury, or disease, is or may be expected to be totally or partially incapacitated for education or for remunerative occupation. In section 4402, which sets forth the duties of the State education department, the department is required—

1. " * * * to use all means and measures necessary to adequately meet physical and educational needs of such children as provided by law."

2. "To stimulate all private and public efforts designed to relieve, care for, cure, or educate physically handicapped and mentally retarded children, and to coordinate such efforts with the work and function of governmental agencies."

The State law in subsequent sections 4403, 4404, and 4405 provides for similar obligations and duties for the city of New York and the school districts outside of the city and their respective appropriate officers and agents. State financial assistance is also authorized and provided as also are approved special teachers, psychologists, and medical help. There is also provision for the establishment of camps for temporary vacations. In addition, if it be found in exceptional cases that the facilities within the State are inadequate, then the State department may send the child at State expense, not to exceed \$2,000, to an institution outside the State found to have appropriate adequate facilities.

This legally authorized obligated service by the State of New York and its agencies is excellent. Modify that by the recognized right of parents to select the school of recognized standards and the service is practically perfect.

It appears to be obvious that the best service that can be rendered to aid the blind and other handicapped persons is direct individual service rather than service so generalized that little of it gets as far down as to reach any of the individuals who are the actual intended objects of the bounty obtained either by public solicitation or legislative appropriation and taxation. In New York State two of the three schools of preeminent reputation in the education of blind children, namely, New York Institute for the Blind and Lavelle School for the Blind are operated by organizations formed for that particular purpose. Funds are required greatly in addition to those provided by State, city, or school district aid.

The land had to be acquired, the building erected, and the equipment and furnishings provided. Maintenance, repairs and additions, including extensions and new buildings, are constant or recurring expenses. There are many other miscellaneous and newly required expenditures wholly outside the items considered in the amount of aid given for the children appointed by the department of education and other State agencies for attendance at the particular school.

Lavelle School for the Blind is a corporation organized under and existing by virtue of the laws of the State of New York. Its purposes stated in its certificate of incorporation are the following:

"Second: The particular objects for which the corporation is to be formed, are to perform such work among the blind, as will tend to promote their mental, moral and physical development, welfare and advancement."

Lavelle School is authorized and does receive money and other gifts and bequests which have been expended for the items referred to and the objects and purposes of the school and corporation. In its maintenance, the annual deficit, beyond public aid, is about \$45,000. This does not include structural or unusual repairs. The officers and trustees render their services without compensation, and the Dominican Sisters, a superintendent and a principal, and qualified teachers of regular subjects and music, who are in residence at the school, directly care for and teach the children, render voluntary service without compensation, except for board and a small monthly donation to the community. In addition, there are lay teachers, a registered nurse, social worker, psychologist, medical doctor, ophthalmologist, and pediatrician. Office dental service is also furnished.

Specifically, I am of the opinion that such Federal aid as is provided for the education and care of blind children socially, medically, and in formal school education should be given directly to the blind as far as that is possible, rather than spread among quasi-public eleemosynary or charitable, educational, or welfare organizations having the avowed purpose of improving or alleviating the condition of the blind through general activities of formulation of rules and regulations, inspection, and visitation, and statistically rating of schools and institutions directly engaged in the care and education of blind, or otherwise handicapped children.

It must be stated with enthusiastic approbation that many such general organizations have been helpful and some have accomplished excellent results for the blind, and otherwise handicapped. What is said here is not intended as criticism of any of them.

It is my opinion, nevertheless, that Federal aid, if given, should be allotted directly to the blind and the handicapped, or appropriated for governmental agencies directly in charge of supervision and regulation, such as those in New York State previously mentioned by me. Public funds should also be provided to aid in training teachers, nurses, social workers, and also ophthalmologists, pediatricians, and psychologists, or to enable them to add to and perfect their specialized aptitudes for the care and improvement of conditions found.

All direct and ancillary public services should have sufficient appropriated funds to supply the needs of blind and other handicapped children. Funds through Federal loans should be made, or direct grants should be provided for one-half the amount needed for capital investment in necessary new buildings or additions, where the particular school seeking aid has on hand the other equal one-half for the necessary constructions and the furnishings and equipment also required. Federal funds should also be supplied, when necessary, for education, care and maintenance, and rehabilitation services at the level of secondary schools.

After careful and protracted consideration of the matter under consideration by your Committee on Education and Labor, the above conclusory suggestions have been determined upon by me. I trust that they will be helpful to your committee.

Mr. ELLIOTT. The subcommittee will now recess until 1:30.

The witnesses, including Mr. Bristow, who did not get here this morning, will be heard first. I will call the list of those who did not come. We will start with them and try to finish today's group by this afternoon.

(Thereupon, at 12:20 p.m., the committee recessed, to reconvene at 1:30 p.m. same day.)

AFTERNOON SESSION

The committee reconvened at 1:30 p.m., upon the expiration of the recess.

Mr. ELLIOTT. The subcommittee will be in order.

We will begin this afternoon by calling the roll of those witnesses who did not appear this morning, who were scheduled.

Mr. Loberfeld.

Mr. Cloud.

Mr. Bristow.

Mr. Bristow, you will be first.

Let me say to all of you that the subcommittee deeply appreciates the witnesses coming here to testify today. The witnesses are numerous. If you possibly can, confine your remarks to a summary of your statements, with the understanding that the full, complete, written statement will go into the record.

With that understanding, you may proceed, Mr. Bristow.

STATEMENT OF WILLIAM H. BRISTOW, DIRECTOR, NEW YORK CITY BOARD OF EDUCATION, BUREAU OF CURRICULUM RESEARCH

Mr. BRISTOW. I have two observations. The first one is with respect to H.R. 3465.

There is a concern on the part of some of us that the administrative operation of this bill in relation to the use of the advisory boards of vocational education may not give the proper balance to the health factors which seem to be paramount in this particular effort to extend

vocational rehabilitation to the employable people without the specific job objective goal.

The task of vocational rehabilitation for employment is very, very large. It is the concern of some of us that we may be getting into kinds of patterns; especially as the administration comes into the State.

That is one observation.

The second observation, and the reason why I value very much an opportunity to come before the committee, is to put into the record a very troublesome problem for teachers and administrators—that is, the development of teaching materials for youngsters, and also the development of suggestions and materials which will help teachers in carrying forward their program.

As the problem of teaching becomes more difficult, and as we enlist the more teachers for special education, we are called upon to provide more rapid means of orientation and to provide teachers with better materials than they have heretofore had.

This is corollary to, for instance, the whole teacher training program—that is, the teacher training program that is projected with respect to blind people seems to me to be something that we ought to encourage.

But corollary to it is the research incident to the production of publication, the distribution and the use of text materials, audio-visual materials, and other materials that are especially adapted to the needs of special education.

You don't have to think very far to realize the need for this with respect to the blind and the hard of hearing, and especially with respect to the retarded.

One of the problems that faces almost every school system and every teacher is the need for getting appropriate materials that can be used, that are adapted to the youngsters under their charge, regardless of the area of special education.

The problem needs both public and private support.

Up to now the text materials and other kinds of materials have largely come to us from textbook companies and others who have found it possible to develop these materials and to get sufficient reward from their sales.

In this area, very often, materials are too limited—that is, the sale possibility is too limited to make them a profitable venture, and, therefore, we need to look for a new and different alinement.

This requires staff work. It requires making it possible for people who otherwise would not be free to work on materials to have time to work on projects of this sort.

Up to now, we have depended upon the good will of the teachers, the interests of the teachers, the interest of the systems, to develop the materials, and to make them then available.

My purpose here is to call, if I may, this important item to the attention of the committee and hope that I might put into the record some other materials which would outline in more detail what some of the possibilities are.

Mr. ELLIOTT. We will be happy to have the additional materials which you have, Mr. Bristow.

Mr. BRISTOW. I would like to submit those, if I may. Is it possible to submit for the record the things that I do not have here?

Mr. ELLIOTT. Yes.

Mr. BRISTOW. Thank you.

Mr. ELLIOTT. If you could let us have those in about a week, let's say in 10 days from today—that will be by the 8th of this November—if you can have them to us by that time, that will be satisfactory.

Mr. BRISTOW. Yes.

Mr. ELLIOTT. Are there any questions of Mr. Bristow?

Chairman BARDEN. May I ask this one question?

Do you recommend in your statement who shall prepare this material.

Mr. BRISTOW. My own feeling is that much of it must be prepared by the school system—the State or the local school system—and that that is chargeable to the instructional program, although I am of the opinion that there are possibilities for developing materials on a larger basis which would eventually get into the regular stream of the publishing industry in this country.

But the publication in the first instance very often cannot be charged against a commercial distribution of a publication.

Chairman BARDEN. You are suggesting that the Federal Government take part in the financing?

Mr. BRISTOW. I am suggesting that we find some way to subsidize the development of such materials either on a State or on a local basis.

For instance, we are subsidizing research at the moment. But almost none of that research is directed toward materials. It is directed primarily at special problems in relation to the retarded—that is, why did they get that way; and how do you deal with them individually?

But the nub of this whole business finally is the teacher working with the youngster in a classroom with certain materials.

Up to now, at least in our experience, the teachers have been largely responsible for developing their materials in their own classroom. I would not want to relieve them of developing such materials as are appropriate, locally.

But we need, and we don't quite know how to do it, to get materials that can be used on a broader basis.

Chairman BARDEN. I just wanted to be sure that you were not suggesting that the material be prepared on the Federal level.

Mr. BRISTOW. No, I don't think it is on that basis. I think there is the possibility, though, of it being prepared at various spots and then being made available through regular channels—not through the Government, but through regular channels, for other people.

We have had a little experience ourselves in relation to the preparation of reading materials for the retarded, and there are instances throughout the country.

But the thing is not pulled together by any means.

Mr. ELLIOTT. Are there any further questions of Dr. Bristow?

If not, thank you very much, Dr. Bristow.

Our next witness is Sister Rose Gertrude, of the St. Mary's School for the Deaf.

STATEMENT OF SISTER ROSE GERTRUDE, ST. MARY'S SCHOOL FOR THE DEAF

Mr. ELLIOTT. You may proceed in any manner you see fit, Sister Rose.

Sister ROSE GERTRUDE. Good afternoon, gentlemen. This is the first time we have ever attended a public hearing on a congressional bill. But we are here today to support the bill that will provide trained personnel to alleviate the handicaps of deafness.

We are from St. Mary's School for the Deaf in Buffalo, N.Y., where there are more than 330 severely deaf and hard-of-hearing children enrolled.

Since 1937 a cooperative program has been carried on between St. Mary's and the University of Buffalo to train teachers of the deaf. The program is approved by the New York State Department of Education, and it is also 1 of the 22 teacher-training centers approved by the Conference of Executives of American Schools for the Deaf for training teachers of the deaf.

There was an estimated shortage of more than 350 teachers of the deaf this fall, and it is expected 500 annually will be needed for the next several years.

Last year at St. Mary's there were 10 in training, and we received 25 requests for teachers from various schools and day classes. We needed five in our own school, so only five were available.

This year there are only 14 in the class. Those from out of town especially find it most difficult to get along financially. Some of the trainees gave up remunerative positions to enter this field, and we hope that they can stay in it.

Many college students visit St. Mary's from Buffalo State Teachers College, Fredonia State Teachers College, and others. They evidence great interest in the work.

But the obstacle of that extra year without a salary seems insurmountable. Teachers are needed not only in schools for the deaf, but also in day classes, day schools, and speech and hearing clinics. The basic training received makes it possible to become not only professional teachers in this field, but also in related fields. Some student teachers trained at St. Mary's have later specialized in audiology, speech correction, vocational guidance, and in administrative positions.

Some of our students have worked at the Walter Reed Hospital. The opportunity is given at the school to work with severely deaf and hard-of-hearing children from the age of 3 to 20, for the program ranges from preschool through high school.

Among these are also multiple-handicapped deaf children, such as cerebral palsy, slow learners, and visually handicapped.

There is need for many qualified teachers to specialize in teaching these children. Some means must be found to facilitate the recruiting and training of teachers in this highly specialized field of deafness and its allied fields.

The problem has become acute. Each year the enrollment of deaf children increases about 400. Last year it was reputed to be 1,200.

You might think this would not mean many more teachers, but for young deaf children, 5 or 6 in a class is maximum, and not more than 10 or 12 can be enrolled in each class for the older children, for

the child totally or severely deaf from infancy is educationally handicapped rather than physically handicapped, who can run and play, laugh and cry, and is apparently normal, yet he has no means of communication with others, no speech, no language upon which depends all intellectual development.

A hearing child who enrolls in a nursery school has an estimated vocabulary of from 2,000 to 5,000 words. A deaf child has none. It requires individual teaching by an especially trained teacher to develop his vocabulary.

At the end of the first year in preschool, he may know a few hundred words in lipreading, but, of course, not in speech.

The teaching of speech to the deaf is the most difficult task of all. The teacher must have the necessary technical knowledge and great skill to succeed. Each child responds differently. One child may require months of patient work and drill to give a clear sound. Another may have difficulty in learning to give K or S and so on, so intensive speech work must continue all through the school years.

Then language must be built up gradually. First, sentences of two words are taught, "I know," "I feel," "I bowed."

Then those of three words, "I have a top," "I threw a ball," then five, "I put a ball on the chair," and so forth.

It will require perhaps 3 years of intensive school work before the child reaches this step in sentence building, before he has mastered the meaning of pronouns, the difference between in and on, under. The proper form of the verb, so that he can use such language principles to express his needs, his thoughts, his experiences.

Then all the question forms must be taught and used, "who," "what," "where," "when," "why."

The English language is conceded to be one of the most difficult to learn. The deaf child has no background of any language to serve as the basis of comparison. His language and vocabulary difficulties last all through his life. He only learns the words he is taught.

The various school subjects have to be modified to meet his understanding.

In the light of the above brief statement, one can see the need for small classes, the need for highly qualified teachers of the deaf, and the need for special schools for the deaf.

Each year, some teachers retire or leave to establish homes, a few receive exchange fellowships to teach in foreign countries, and these and other causes deplete the ranks of trained teachers.

At St. Mary's, we try to give a little help financially to 10 prospective teachers each year, to enable them to take the training course. We use their services as substitute teachers for special coaching, teacher aids, and the like, and pay them as assistant teachers. The cost of living and the classes, however, is high, and the trainee finds it very difficult to get along, especially after just finishing college.

We hope this proposed bill, H.J. Res. 494, will supply the help that is so desperately needed to train teachers for those who are afflicted with deafness.

The deaf child has a God-given right to the education that will make him a happy, self-respecting, self-supporting citizen. Only those teachers who are especially trained can reach the mind closed by deaf-

ness, and so develop and educate the child physically, intellectually, socially, and spiritually.

Thank you.

Mr. ELLIOTT. Thank you very much.

Do you have any questions, Mr. Barden?

Chairman BARDEN. No questions.

Mr. ELLIOTT. Mr. Daniels?

Mr. DANIELS. I have no questions.

Mr. ELLIOTT. Mr. Giaimo?

Mr. GIAIMO. No questions.

Mr. ELLIOTT. Are there any questions?

If not, thank you very much for a very fine presentation.

Our next witness is Dr. S. S. Bluestone, director of the New York State Rehabilitation Hospital.

STATEMENT OF DR. S. S. BLUESTONE, DIRECTOR, DEPARTMENT OF HEALTH, NEW YORK STATE REHABILITATION HOSPITAL

Mr. ELLIOTT. We are very happy to have you, Doctor. If you can, summarize your views with reference to these several matters in about 10 minutes.

Dr. BLUESTONE. I believe I can, sir.

I am a physician, director of the New York State Rehabilitation Hospital at West Haverstraw, which is a unit of the New York State Department of Health.

Our commissioner has asked me to express his regrets at being unable to attend this hearing, but he does hope to attend later hearings of the committee concerning H.R. 3465.

I have been told to state that my statement does not necessarily represent the views of the Governor of the State of New York.

Briefly, on my own qualifications, I have been in medicine for 16 years, and that included 1 year as public health and welfare officer in the U.S. Military Government in Korea. I engaged in private practice of medicine after having been formally trained in the field of pediatrics; since 1954 I have been solely in the field of rehabilitation, both clinically and as administrator, being in my present position since July 1957.

Mr. ELLIOTT. Where is this rehabilitation center?

Dr. BLUESTONE. About 40 miles from New York City.

I am assistant clinical professor of clinical medicine at New York University, and also a member of the New York State Interdepartmental Health Board.

The hospital has 204 beds, which are devoted exclusively to rehabilitation and provide comprehensive services to patients of all ages and to the wide variety of disabilities, which include spinal cord injuries, strokes, cerebral palsy, arthritis, and many others.

The hospital has a mandatory daily charge of \$13, about half of the cost, the deficit being met out of State funds each year.

For the purpose of attracting the participation of the welfare departments in a special project, we established a reduced rate of \$5 per day for patients referred to by welfare departments.

I am very strongly in favor of the aims of H.R. 3465, particularly as regards the provision of rehabilitation services for handicapped

adults, whose potential may be somewhat less in employment or re-employment.

The rehabilitation hospital now has to turn away many such people whose means do not permit personal payment of even our modest rates but who, nevertheless, are not eligible for financial assistance under existing programs.

Truly, the hospital is unable to serve all of those who are referred. We have a waiting list now which is about equal to half of our capacity, and admission delay is estimated at 2 to 3 months.

However, it is not in keeping with our philosophy to have to select our patients on the basis of their financial resources. It is too well known that disability is accompanied by loss of income and exhaustion of savings.

Under this pilot welfare project that I mentioned, we admitted a total of 540 disabled welfare recipients. These people were not eligible for our services under the vocational rehabilitation laws.

Of the 540, I might mention that all of them presented the worst physical, social, and psychological problems that we see.

Of the 540, we selected a random sample of 99 who have been studied in their home communities 6 months and longer after discharge from the hospital.

Viewed from the standpoint of personal care alone, there were 71 individuals who at the time of admission required attendant care. Of these 71, 28, or 39 percent, were completely independent at the time of the field visit 6 months or longer after discharge from the hospital.

Of those, some were completely independent, even outside the home.

Of 11 individuals who prior to admission were able to take care of themselves at home, 5 were able to extend their activities outside of the home. Many others made lesser gains. While wholeheartedly endorsing the principle of H.R. 3465, I recommend its amendment so that the Governor in each State will be allowed to select a particular agency in that State best qualified to administer the independent living program, and so that the State and local health departments would be required to participate in the provision of medical services under the bill.

Operating rehabilitation service programs have become identified as being medically oriented or vocationally oriented, each discipline having relatively minor assistance from the other and each having personnel in the professions of psychology and social services.

The population to be served under this bill by these definitions has no object of use vocational prospects. The primary need, therefore, is for medical and allied services.

The wording of the bill itself recognizes this in its words of services, section 206(a) and of rehabilitation services, section 403, and in its requirements for grants for rehabilitation facilities, section 302 (b) (2) (B).

The vocational agency and professional personnel in the vocational field can be expected to play no more than an incidental role and that only if the vocational potential becomes manifest in the patients as a result of medical services.

It is my belief that even the existing vocational rehabilitation program would benefit if the medical aspects of the program were administered by a medical agency.

The proposed program, under H.R. 3465, is a radical departure from the deeply ingrained work-oriented philosophy of vocational counselors in vocational agencies.

On the other hand, in New York State, for example, the health department is represented by important elements in every county. A physician administrator, the health officer, is in charge, whose training includes medical, social, and psychological aspects of chronic disease and disablements. He knows the available skills in the county, the hospital and treatment facilities intimately. He is already providing medical, nursing, and physical therapy services and even social service. Through his friendship and liaison with the practicing physicians in the area, the health officer already identifies those individuals who need rehabilitation services immediately after the onset of their disability, when such services are most valuable and most effective. As a physician, he has the respect and confidence of other physicians and can readily translate the short technical reports of the other physicians into terms which are readily understood by the allied professional people.

The health officer is already providing the necessary support of services to help the patient retain his independence. The rehabilitation hospital and other similar centers make routine referrals to units of the health department in New York City. The State and local health departments are already active in research to complete the needs of the nonemployable, aged, and disabled.

The New York State Department of Health is already providing training funds and programs for the various specialists needed in rehabilitation. It already has an extensive program of public education, geared to the prevention of disability, and to the prevention of the secondary effects of disability.

Finally, the New York State Department of Health already has proven channels for interagency cooperation and referral with the State and county departments of welfare, with the division of vocational rehabilitation of the State education department, with the department of mental hygiene, with a large number of voluntary and public agencies.

In conclusion, I have indicated that the means to achieve independent living as defined in H.R. 3465 is through the provision of medical services. But such services should be administered by a medical agency and, in New York City, the health department is eminently qualified to undertake its administration.

It is urged, therefore, that the bill be amended to permit each State's Governor to designate the agency in that State to administer the bill, but that he be required, in any event, to place the medical aspects of the bill under the direct supervision of the State department of health.

Thank you, gentlemen, for the privilege of being permitted to express my views.

Mr. ELLIOTT. Thank you very much, Doctor.

Are there any questions?

If not, we thank you very much for the information you have brought us, Dr. Bluestone.

Dr. BLUESTONE. Thank you.

Mr. ELLIOTT. Our next witness is Mr. Ben Light, secretary, Ithaca College.

STATEMENT OF BEN LIGHT, SECRETARY, ITHACA COLLEGE,
ITHACA, N.Y.

Mr. ELLIOTT. How far is it to Ithaca, Mr. Light?

Mr. LIGHT. Two hundred and forty miles.

My statement will be rather brief. I am representing Dr. Dillingham, who is unable to appear here today.

Ithaca College supports wholeheartedly the proposed legislation in the bill and resolutions.

We prepare teachers of speech and emphasize correction, but do not feel that our experience in this field permits us to make practical suggestions regarding the training of teachers for the deaf, or speech pathologists and audiologists as outlined in the resolutions.

With regard to H.R. 3465, we do feel that our experience permits us to call your attention to the following facts and to make a special representation for Federal aid for physical plants, families, and workshops in the fields of physical therapy, recreation, health and physical education.

Our school of health and physical education was initiated by the college in 1926. Since 1931 we have awarded the bachelor of science degree of 1,852 men and women majoring in physical education. Most of these graduates are currently employed in public school systems of New York and many other States, while others are teaching in private schools and colleges.

O division of physical therapy was started in 1948 and has graduated 278 men and women since that time.

Mr. ELLIOTT. What was that date?

Mr. LIGHT. 1948.

Practically all are now engaged in professional work in this field.

We have enrolled currently 98 physical therapy majors who study at our Ithaca, N.Y., campus for the first 3 years. Their senior year is spent studying at Albert Einstein Medical College in New York City, with whom we are affiliated. After the academic work is completed in June of their senior year, our students engage in concentrated practical application of therapeutic methods at four hospitals in this medical center before being permitted to take the New York State licensing examination for physical therapists. The complete 4-year program is under the direction of an eminent doctor of physical medicine, Arthur S. Abramson.

Most of our graduates from the School of Health and Physical Education are in the fields of physical education and recreation. The emphasis there, as you know, is on fitness and prevention, rather than rehabilitation.

Our physical therapists, on the other hand, under medical supervision, specialize in rehabilitation, particularly in the area of crippling diseases and injury.

There is definite need for adequately trained physical therapists and we, as well as other colleges, want to train and develop more of them. Our problem, however, is a simple one. We do not have enough adequate facilities or equipment to train more students than we have now. Financial aid is becoming more available in the field of the national and physical sciences, the social sciences and the humanities. Unfortunately, this is not so in the areas of physical therapy and

physical education. It does not seem likely that such aid will be forthcoming to schools such as ours, which is a private, nonendowed, completely self-supporting college, unless it comes from the Federal Government.

We need financial aid for additional plant facilities, workshops in physical therapy, and recreation, and for therapeutic equipment.

Legislation enacted by the Congress in these areas will be welcomed.

Ithaca College is a fully accredited liberal arts college. However, our experience in special education dates back to 1892, the year of our founding, and includes education in the fields of music, drama, television, and radio as well as the aforementioned speech, physical therapy, physical education, and recreation.

Mr. ELLIOTT. Thank you very much.

Are there any questions?

If not, our next witness is Mr. Sol Tapper of the Parent-Teacher Association, School for the Deaf and Hard of Hearing.

Mr. Tapper, may I urge that you summarize your views and opinions with reference to this matter, and then that your statement in writing be given to us within 10 days, if you do not have it ready at this time.

**STATEMENT OF SOL TAPPER, PARENT-TEACHER ASSOCIATION,
SCHOOL FOR THE DEAF AND HARD OF HEARING, JUNIOR HIGH
SCHOOL 47**

Mr. TAPPER. I have not any prepared text. I think I could summarize the picture and the viewpoint of the PTA of Junior High School 47.

Mr. ELLIOTT. Thank you.

Mr. TAPPER. I represent the PTA of Junior High School 47, which I consider and I think is the largest deaf school in the United States. It is known as a junior high school but it starts with children at three and a half, pretraining, until they are ready to enter high school level.

Actually, the witness you had from St. Mary's School for the Deaf was an excellent witness in outlining the situation and the problems of a deaf child.

I think the résumé presented to the committee really brought out the actual problems that a deaf child has.

I believe Representative Daniels, from New Jersey, this morning questioned a witness and asked the difference between a speaking child, the one that has oral speech, and the number that are completely deaf, that cannot give any type of speech. I did not get the answer that the witness rendered, but, at the outset, I would like to state that there is a vast difference between a child that is born deaf and one that becomes deaf later in life. A child that is born deaf, that never did have any type of hearing, or could not hear sound, is a far greater problem than a hard-of-hearing child.

There is a vast difference between a deaf child and a hard-of-hearing child.

Federal aid we believe can help, and where we find the greatest shortage, is in the teachers of the deaf. There are not enough of them.

The Federal Government can aid them in some sort of a plan whereby they can scholarship teachers or induce them to enter this field.

There is a shortage of speech pathologists which are sadly needed. Audiologists are needed, as well as psychiatrists and psychologists.

I do not know if it is within the committee's jurisdiction, and from what I read in the bill, it is not in there, but I also consider that the training of the deaf is made by a team, a team of teachers, audiologists, psychologists, and psychiatrists. There is a vast shortage of psychologists and psychiatrists, very few that know the problems of a deaf child or are cognizant of them. They should be associated at a deaf school, trained at a deaf school to know what problems this child will reach when he reaches maturity, and be able to guide parents, mainly, and the child, to live a normal and healthy life.

House Joint Resolutions 494 and 316 cover a good portion. The PTA is for it. We are very happy to see that the Federal Government is stepping into the picture of rendering some sort of aid.

Another thing that we feel they can also render would be training films that can be distributed to parent-teacher associations. We find that the parents can do a lot with a deaf child at home. They can aid the teachers with that. His life at home has to be a normal existence because the deaf child has to live in a normal world. He has to be integrated. If he is shunted and moved around from situations and place to place, it is wrong.

Training films and literature by the parent can aid this child at home, would aid all the teachers and all the psychologists just as well and cut down the problem of psychiatric care later on.

In the rehabilitation field, the problem has always been what happens to the deaf child when he is graduated or when he finishes his formal training at a school.

H.R. 3465 includes, I notice, the deaf with the other physically handicapped. In my estimation, there has been very, very little done for the deaf person after he does leave his formal training.

What will he do in his normal life? What field of endeavor will he enter into?

The Federal Government can, I believe, aid in working with State rehabilitation groups, to survey the field of private industry, educate private industry to accept these physically handicapped deaf people, what types of jobs they can do, whereby communication or their speech will not hinder them in any way.

There is a lot of work to be done in that field, where later on they can go on and earn a fair living and have a regular place in the world.

Maybe the Federal services can be surveyed to see what type of jobs can be opened up to deaf individuals, where the physically handicapped portion can be eliminated, where they can compete with normal hearing people for certain types of jobs.

There is where I believe the committee can aid greatly in helping the deaf person.

In closing, all I can say is to thank the committee and bring the thanks of the parents of the Junior High School 47, and maybe I will say the parents of all deaf children. They are quite happy to see that

legislation is on its way to aid in this field that we believe was forgotten for quite a number of years.

Mr. ELLIOTT. Thank you very much, Mr. Tapper.

Your testimony will be very helpful. We appreciate it.

Our next witness is Mrs. Shirley Kurs.

Is Mrs. Shirley Kurs here?

If not, our next witness is Mr. B. Scher.

Mr. Scher is the executive director of the Girls' Service League. If he is not here, the next witness is Mr. A. W. Sherman, executive director, The Lighthouse, New York Association for the Blind.

Is Mrs. Alma W. Fraas here?

STATEMENT OF MRS. ALMA W. FRAAS, ADMINISTRATIVE ASSISTANT, IN BEHALF OF A. W. SHERMAN, EXECUTIVE DIRECTOR, THE LIGHTHOUSE, NEW YORK ASSOCIATION FOR THE BLIND

Mrs. FRAAS. I am Mr. Sherman's administrative assistant. He asked that I file his statement with the committee.

Mr. ELLIOTT. Without objection, the statement mentioned by the assistant to Mr. Sherman, will be made a part of the record at this point.

(The statement referred to follows:)

STATEMENT BY ALLAN W. SHERMAN, EXECUTIVE DIRECTOR, THE NEW YORK ASSOCIATION FOR THE BLIND

Mr. Chairman and gentleman, the following material has been prepared by members of the professional staff of the New York Association for the Blind as the result of many years of practical experience in providing services to 5,000 blind people each year. It is respectfully submitted for consideration by your committee.

I. EMPLOYMENT OPPORTUNITIES NEEDED FOR BLIND PEOPLE

In spite of the great progress made in securing acceptance of properly trained blind persons in the labor market there will remain many areas where employment could and should be extended. Some of these needs are as follows:

1. *Placement of professionally trained blind persons.*—In order to fully utilize the abilities of blind persons with ability, study of those already in professional or semiprofessional positions needs to be made to secure a body of knowledge about such opportunities which would then be useful in counseling those persons contemplating advanced study and which would be essential in helping these trained individuals in suitable job placement.

Because this is a nationwide need and problem, Federal funds would be helpful in providing the study indicated and in stimulating greater activity in this area.

2. *Examination of civil service laws and other "discriminatory regulations."*—Many public positions, both Federal and State, requiring professional training, often come under civil-service laws and regulations. Changes may be necessary to make these opportunities a reality for qualified blind persons. Civil-service and other requirements should not be discriminatory against blindness. The emphasis should be placed on qualifications and abilities, not on disabilities. The solution of this problem may require legislation, but as a study it would include both Federal and State discriminatory laws and regulations. Such a study, because of its broadness, could best be financed through Federal grants-in-aid.

3. *Placement agents and counseling services needed.*—Standards for counseling and placement services for blind persons should be raised and opportunities for training stimulated and traineeship programs broadened and extended. While much has been accomplished in this area under Public Law 565, more needs to be done. A key factor in this area would be the establishment in State

programs of work opportunities with pay scales commensurate with the importance of these jobs and the training required. To stimulate such raising of standards and compensation rates, grants-in-aid to cover such administrative costs which meet standards that have been agreed upon and set should be considered.

4. *Employment services and opportunities for homebound blind persons.*—One of the most difficult yet challenging problems in work for the blind are adequate programs to provide employment opportunities for blind persons who are homebound. In a great urban area such as New York there is great need for such opportunities under proper regulations. Following a pilot study done in a rural area, there needs to be a pilot project in an urban area. This might best be done under the auspices of a voluntary agency and should probably utilize other handicapped individuals as well as blind persons. Because of the heavy cost of such a program, only through the encouragement of substantial Federal grants-in-aid would agencies be able to enter into such an important project.

5. *Piano tuning and repairing.*—There is still a good opportunity in this type of work for properly trained blind persons. What is needed are training centers, equipment and staff to produce well trained tuners and repair men. Federal grants to voluntary agencies or educational institutions would stimulate the development of centers for training in this technical, practical, job opportunity.

II. EMPLOYMENT PROBLEMS RELATED TO WORKSHOP

Workshops have become an integral and important part of rehabilitation and employment services. It is generally agreed that workshops fulfill two objectives: (1) training and (2) providing terminal employment of less skilled persons, multiple-handicapped and older persons.

As training facilities, workshops are a part of an overall program of service to blind persons. The objective of training programs should be to place qualified blind persons in the competitive labor market through selective placement.

For those workshops providing terminal employment, there is need for modernizing programs in order to increase the productivity of such persons to enable them to earn more adequate wages.

The Wagner-O'Day Act has helped considerably in workshop programs for blind persons. Public Law 565 has helped some in the development of workshop facilities. Now and in the future there is a great need to stimulate and help workshops raise their level of operation through studies of manufacturing processes, marketing and product research. This is a very difficult area of work and for too long we have been satisfied with the manufacture of products which have come to be related to stereotypes of blindness. The workshops which now are having to work with persons with little ability are still having such people engage in "craft type" operations in which a high level of skill is not required. This results not only in poor work but in meager production which can only produce low wage rates.

Workshops must be encouraged to provide working conditions which will permit maximum efficiency, using the most modern manufacturing techniques and automatic devices in order to increase the productivity of this labor. This will require research and study and the utilization of engineering and technical skills which a single workshop will find it difficult to afford. Therefore, it is urged that Federal funds be made available to stimulate and assist progressive workshops or even the National Industries for the Blind in moving ahead in this important area.

A corollary to such a program would be the training of foremen, supervisors, and administrators for such workshop programs.

III. MEETING THE NEEDS OF OLDER PERSONS

While voluntary agencies such as the Lighthouse, the Industrial Home for the Blind, and the New York Guild for the Jewish Blind, have for many years provided programs of service for older blind persons in an effective way, stimulation should be given to increased activities in this area which would help to raise the standards of rehabilitation for this group which constitutes the majority of the blind population. The use of centered and field work programs for providing such services should be encouraged and services should be at a

higher level. Our conception of rehabilitation for this group should include provisions for self-care and more independent living.

There is need for improvement of facilities for those blind persons who are also chronically ill. We are not suggesting segregated facilities for them but rather a way to provide staff in existing hospitals for the chronically ill to serve persons who are blind.

IV. PUBLIC LAW 565

This law has provided great stimulus for rehabilitation services and programs. We should like to make the following observations and suggestions regarding programs established under this law:

1. *Specialized services for blind people.*—We sincerely believe in the need for specialized services for blind persons and we urge the retention of such services in States where this has proven to be the best service for blind persons.

2. *Financing through the States.*—One of the problems which has developed in these programs has been the inability of State programs to adjust to important changes which occur in caseloads. Perhaps a study of the formula through which Federal funds are provided should be worked out so that State programs would be able to adjust more easily to changes in caseloads.

3. *Service standards and purchase of service.*—Through this law, service standards have been raised in both State and voluntary agencies. As a principle, it is essential that service purchased from voluntary agencies should be as close to the cost of providing such service as possible.

4. *Training blind people for general work.*—While it is immediately related to State regulations and sound counseling, we would suggest that opportunities be made to train blind people for general work as well as for specific jobs.

5. *Elimination of delays.*—We need to eliminate the delays between the time vocational objectives have been established and the date of authorization.

6. *Case loads.*—A study of projected case loads would indicate a need for expansion of these programs under Public Law 565.

V. LAWS RELATING TO VENDING STANDS

Operation of vending stands has proven to be one of the most feasible business opportunities for proper qualified and trained blind persons. The legislation which provides help to blind persons in this area of employment needs to be carefully studied and brought into line with existing realities in such a way as to protect the interest of blind persons. Such areas as the following are—

1. What shall be the relationship between the vending-stand program for blind persons and other programs of General Services Administration?

2. How should the vending-machine program be handled by State and voluntary agencies engaged in vending-stand programs?

3. Can some provisions be made for the purchase of existing small businesses to provide an opportunity for qualified blind persons?

VI. SUGGESTED REVISIONS OF THE SOCIAL SECURITY ACT

While such matters may not be considered within the work of this committee, the following areas of need are indicated because of their importance to persons who are now blind or who may lose their sight in the future:

1. *Amendment to title II.*—An amendment to title II of the Social Security Act to provide disability insurance payment to persons who lose their sight would be desirable. We are fully in agreement with the provisions for such amendment as are embodied in the Anfusco bill (H.R. 8218) and the Bosch bill (H.R. 8219).

2. *Revision of title X.*—This section of the Social Security Act, relating to the program for aid to blind people through the State should be revised in order more adequately to meet the special needs of these people and to reduce as much as possible the pauperizing effect of the present law.

To bring this about we suggest that more adequate and frequent review be made of individual persons by staff and supervisors trained in working with blind persons. We recognize the practical implications and problems of such a recommendation, but much stimulation could be given to the adequacy of training of public welfare workers.

It is suggested that the limit be raised for individuals on real property, real estate, savings, and insurance in accordance with some formula to be determined

which will enable blind persons, particularly older blind people, to retain some of the results of their labors during their productive years.

3. *Revise section devoted to "earned income" (title X).*—A revision of this part of the Social Security Act should be made to encourage blind persons now on relief to engage in employment to the end that they would eventually become self-sustaining.

The \$50 of earned income now exempt from being considered as a resource has helped to encourage blind persons to work, but this does not go far enough because it does not enable the blind person to reach the point where he is able to leave public-assistance rolls. We suggest amendment of these provisions to establish a sliding scale so that a blind person might retain at least 50 per cent of his earnings up to a maximum of \$1,200.

Mr. ELLIOTT. Our next witness is Dr. J. A. Brussel, assistant commissioner, Department of Mental Hygiene, State of New York.

**STATEMENT OF DR. J. A. BRUSSEL, ASSISTANT COMMISSIONER,
DEPARTMENT OF MENTAL HYGIENE, STATE OF NEW YORK**

Mr. ELLIOTT. Dr. Brussel, you may summarize your statement with the understanding that it will be filed when you are finished.

Dr. BRUSSEL. Mr. Chairman and gentlemen, thank you very much for the privilege and honor of appearing before your committee.

The subject of special education as encompassed in H.R. 3465 and S. 772 has a specific implication for those of us who deal with the mentally ill and the mentally retarded, particularly from the standpoint of institutionalization.

Present mental hygiene statistics, taking into account therapeutic progress and the projection of mortality tables, plainly indicate that within a decade our institutions will be housing only the very young and the very old. Therefore, it is obvious that two problems will be manifold as time progresses: the institutional care and treatment of youth and old age.

First, the question of the elderly. It is estimated that in the next 15 years, out of a total population of 200 million, somewhere in the neighborhood of 35 million citizens will be in the 60-and-over age bracket. Psychiatry of itself is not the exclusive answer to the ever-increasing geriatric challenge in this country. Nor are recreation centers, specially designed living quarters, and doles the panaceas. The oldsters who regard leisure and retirement as synonymous with inactivity and fail to find gainful employment, feel rejected and inferior and swiftly are imbued with overwhelming depression and a sense of futility. It is one thing to speak of psychiatric rehabilitation and reeducation. For what is the aged person being rehabilitated and/or reeducated? Many individuals over the age of 65 are physically, mentally, and emotionally equipped to carry on work they had been doing in earlier years with comparable efficiency—or, to easily learn and perform a new trade or occupation. The immediate inference would seem to be rehabilitation and reeducation.

Mr. ELLIOTT. It is rather cruel, is it not, Doctor, that we practically drive people from the work force who are 65 years of age, when, as you said, in many instances they are at the height of their powers.

Dr. BRUSSEL. That is correct, sir.

But these oldsters cannot find work. Our ever-increasing social consciousness benefiting it superficially promises, actually guarantees,

that the elderly should not be hired because, for example, social security benefits are available for men and women at 65 and 62 respectively. Similarly, it is a well-known fact that employers, with rare exception, are averse to hiring applicants over the age of 50, and more usually, 45.

Considering the staggering challenge of old age, it appears that rehabilitation and reeducation, per se, are not the answers. Gainful employment, to counteract the lack of hope in these elderly persons, is of paramount importance. Otherwise, unable to hold up their heads, to face senility with hope and self-respect, nothing but depression, futility, and enforced dependence on a handout become the prime factors accounting for the ever-increasing numbers of the aged who suffer with mental and emotional disorders. Thirty years ago only 2.5 percent of all first admissions to mental institutions were in the over-60 age bracket. Today this group is in excess of 40 percent of all first admissions.

In the field of the very young, one must contemplate the devastating problem of juvenile delinquency in which emotional disorders play a prominent role. Statistics, as furnished by the New York State Department of Mental Hygiene, plainly indicate a marked relative and absolute increase in child psychiatry with a large component of behavior disorders. It is felt that we must have far more community psychiatric facilities, probably started in a pilot project, as we suggest, established in urban localities than are available today.

Rapidly rising juvenile delinquency is uncovering more and more youngsters with mental and emotional disorders who require hospital treatment. This automatically implies a demand for increased educational facilities within such institutions, but these cannot be mere carbon copies of ordinary schools within the community. Principals and teachers must be fortified with special training in the handling of these youngsters.

Similarly, since it is obvious that few of these children are endowed with the mental and emotional capacity to pursue higher academic education, the institutions caring for these youngsters should have a wide range of vocational training modalities as a major facet of the education program. Education would, of course, be combined with psychotherapy.

It should be recognized that juvenile delinquency is an expression of the youngsters' resentment of, disregard for, or rebellion against authority—the teacher, the policeman, et cetera. It is recognized that the lack of esteem for authority is directly traceable to the home where the child should have first learned his respect for authority, i.e., the parent.

Obviously, the question arises as to where therapy and education should be administered. The permissive atmosphere of a mental hospital is frustrating to those who wish to treat these youngsters. The primary difficulty to be overcome is the seeming disregard for, and/or hostility toward, authority. Neither coddling nor the best oriented therapeutic or educational program will materially alter such social deviants. But this program of psychiatric treatment, education, group activity, vocational training, et cetera, will be far more effective in a milieu where discipline can be enforced, where it is statutorily permissible to punish as well as to reward. Strict

discipline and humane punitive measures cannot be followed in a mental institution; they can, however, within a correctional setting.

An ever-increasing problem is encountered in the field of mental retardation, the numbers of which are mounting at an appalling rate. Formerly, for example, mongolians and mongoloid infants seldom survived the age of 2 because of fatal intercurrent infections. Today, thanks to antibiotics, these children are living and attaining advanced age.

If any funds are to be appropriated for the training and education of mentally retarded children, this speaker feels that to do so would be taking a potshot in the dark.

Research and investigation are more important, if we are to properly spend tax money for the purpose of battling the challenge of mental retardation. Certainly an attempt to discover the cause or causes of mental retardation, with a view of prevention, is a scientifically sound approach.

Likewise, a survey to discover in what areas mental retardation is more acute than in others, is also indicated.

In New York City alone, 3,000 to 4,000 mentally retarded infants are born every year. It is estimated that 3 percent of the American population is mentally deficient. However, if "borderline" intelligence is included—an IQ range of 70 to 75—that figure becomes 4 percent. It is amazing, nevertheless, that only three one-hundredths of 1 percent of all grades are institutionalized.

It is interesting to note how this hospitalized group is distributed in the three categories of mental deficiency—considering intelligence level only for this immediate presentation—because an appreciation of this clinical-statistical phenomenon must influence the approach to therapy, on which lay and medical authorities differ, as we shall see. The distribution of the hospitalized defectives is as follows:

Percent of total:

IQ range

30-----	0-19
50-----	20-49
20-----	50-70

It is more advantageous and helpful in any plan to regard mental defectives as the acutely retarded who are totally dependent, moderately retarded who are trainable, and mildly retarded who are educable.

The overwhelming bulk of hospitalized defectives is the severely and mentally retarded groups. They present, primarily, physical and psychiatric handicaps. Only a very small number are in institutions for academic training.

This, then, is the irrefutable answer to well-meaning but uninformed groups who believe the panacea for institutionalized defectives is special education.

It appears to this writer that special centers, within the community for the education of mildly mentally retarded children, is far more preferable. While supervision of such centers should be under the jurisdiction of local boards of education, planning, guidance, and consultation should be provided by psychiatrists and those skilled and experienced in the approach to the treatment of mental retardation.

Thank you, sir.

Mr. ELLIOTT. Thank you very much, Dr. Brussel, for a very helpful statement.

I recognize the gentleman from North Carolina.

Mr. BARDEN. I did not have a question, but I wanted the record to carry this as a reminder to all of us: Of course, I have been interested in this rehabilitation for many years, but there is the practice grown up in the Government at this time which disturbs me. I know it is the practice in Navy installations where they have these repair shops and so forth. That is, in spite of the fact that every year the President issues a proclamation to the Nation encouraging the employment of the physically handicapped, yet the practice is that if, upon a physical examination, they find a man physically handicapped, maybe the doctor will say that he cannot climb high ladders, and he is a painter, that he cannot do that, they just fire him and recommend that private employment take him up. The whole building has to be painted, and it would make better sense to me if they put him to work painting the lower part of the building and let those who can climb the high ladder paint the top of the building, rather than fire him. Nevertheless, they will do that. Of course, if the disability did not arise as a result of his work, he is thrown out without any compensation, and private employment is not very ready to take him, maybe one or two painters, unless the painter can paint the whole building.

It does not make any sense to me for the Congress to pass every kind of law that we could figure out would be helpful up to now, and it be the policy of the Government to encourage the employment of the physically handicapped, if one department of the Navy just takes off in the other direction and fires anybody they can unless he is 100-percent efficient.

Dr. BRUSSEL. Mr. Barden, there can be a more useful generalized principle to assist in the point you are trying to make, and that is if each individual was inventoried for his assets rather than his liabilities, then those assets might well be exploited for the mutual benefit of the individual himself and for the service.

Mr. BARDEN. Of course, he could be.

I have been in the same shop, and the chairman knows what I am referring to, with some 4,000 employees, where part of them did work sitting at a table. Yet, if they find one of those that cannot do the work that is 'way up high, or something like that, instead of letting some man at the table who is capable of doing it do the other work and put the first man at the table, they just fire him.

I will close my statement by saying that I think if the one responsible for setting the policy in the Navy Department for the civilian personnel was called before the committee to explain just why that happens, I believe it would be a start toward the changing of policy. I think it has just been permitted to continue. But living right near one of these bases, I am becoming pretty sensitive to it because about half a dozen a week come to see me to see if I cannot get them back. You know about what chance that is when some doctor says, "No, he should not climb a ladder," and the colonel says, "If he cannot climb a ladder, fire him." That is it.

Mr. ELLIOTT. Thank you very much, Mr. Barden.

Thank you, Dr. Brussel.

Dr. BRUSSEL. Thank you.

Mr. ELLIOTT. Our next witness is Miss H. F. McLaughlin, principal, Board of Education of New York City, Junior High School 47.

I hope you will summarize your statement, Miss McLaughlin. If you will, we will be grateful.

You may proceed.

**STATEMENT OF MISS H. F. McLAUGHLIN, PRINCIPAL, BOARD OF
EDUCATION OF NEW YORK CITY, JUNIOR HIGH SCHOOL 47**

Miss McLAUGHLIN. We are very grateful that you are interested in this problem of teaching the deaf, and that you are going to use your efforts to do something about it.

We heartily endorse your bill for a teacher training program and hope that it will contain some incentives to encourage people to go into this very difficult area of teaching, with scholarships to carry on their training.

In addition to this, we find a few other unmet needs that are very important in this field. There is a lack of adequate diagnostic facilities in examining children who present multiple problems so that proper recommendations for an educational placement can be made.

The team needed for this project would include a psychiatrist, psychologist, social worker, and a secretary, as well as members of various medical and teaching groups concerned.

There has been a noticeable growth in the number of atypical children over the last few years. We know so much more now about hearing than we did 20 years ago, and about other factors. We did not know about the Rh factor 20 years ago, and that it resulted in deafness and in destroying other areas of the brain.

The rate of infant mortality has declined in the last 50 years; 90 percent of the babies who used to have meningitis died from it. Now 90 percent live. As a result of the drugs that are used in this, they are brain damaged, deaf, mentally retarded, or have some other ailment.

You heard from the gentleman who spoke before me of the problems of the mentally retarded. I assure you the mentally retarded deaf present a much bigger problem. It is very, very difficult to reach them.

We have so many premature babies. That is all anoxia and that results in deafness. We did not know about that some years ago.

We have a great deal more knowledge about the workings of the ear and the brain than we used to have, and there have been many revealing developments in measuring hearing. We know now that very few babies, if any, are born totally deaf, and this little residual of hearing that they have can be stimulated from very early in life, and then they become more like hard of hearing children than like deaf children, when they do not grow up in an entirely silent world.

Many such children apply to my organization for admission. My concern is to find out just what the problem is and what the proper educational program should be for them and where that exists.

Another unmet need is a pilot project in prevocational training and testing for these multiple handicapped children. We work very closely with the Bureau of Vocational Rehabilitation, and they say they will train these children for us if we tell them what they can do. We do not know what the child is able to do, what a mentally retarded

deaf child can do. But we think of a pilot project set up in a large area such as New York City, in that the results would benefit similar children all over the country. We have more because of being in the metropolitan area. Beyond that, there are very few places that have readily available information to help older deaf.

I have problems presented to me all the time from different organizations and from parents of children who have left the school.

One such problem, to illustrate, would be a hospital might call up and say that "a deaf woman is going home with a newborn baby. What about that baby when it cries at night? She will not be able to hear it."

Well, there is an equipment, something that has been invented, with a little microphone that hangs over a baby's crib, and a wire that lights the light at the mother's bed and flashes the light on and off so that she will wake up and tend to the baby. But there are not many deaf who know about that.

I would like to see a regional office set up in different large areas, like Los Angeles, Chicago, New York, where many of these problems, such as that type of problem, or social security information, or other information that the deaf need, could be made available to them, because they are a very isolated group.

To make, of course, all these problems improve, we need research in this area.

Thank you very much.

MR. ELLIOTT. Thank you, Miss McLaughlin.

(The following statement was submitted by Miss McLaughlin:)

STATEMENT BY MISS H. F. McLAUGHLIN, PRINCIPAL, BOARD OF EDUCATION OF
NEW YORK CITY, JUNIOR HIGH SCHOOL 47

Gentlemen, educators of the deaf are very grateful to you for your interest in this field of education and for your efforts to help. Teaching the deaf is acknowledged to be the most difficult pedagogical problem with the single exception of the deaf and blind. I shall list a few of the unmet needs.

I. A TEACHER TRAINING PROBLEM

We heartily endorse your proposal as described in House Joint Resolution 494 (86th Cong., 1st sess.) to evolve and carry forward a planned, structured, training program for teachers and audiologists. While we are aware of the value of this proposal to training centers throughout the country, in New York City we have no difficulty in obtaining training under the New York State fifth-year program. Our problem is one of recruitment. Unless some salary incentive is made available, candidates will continue to be unavailable in this very difficult area of teaching. Out of 96 teaching positions in the school where I serve, only 41 teachers are licensed teachers of the deaf.

May I point out here the need for incorporating into the final bill—training other people to work with deaf children if the school program is to function successfully. These include social workers, psychologists, and psychiatrists who are oriented to the handicap of deafness.

Section 106(a): The suggested appropriation of \$1,500,000 for the year 1959-60 appears to be somewhat inadequate for a total program of training sufficient teachers of the deaf. Along with maintaining scholarships (for which the cost is increasing), there is research needed to evaluate these programs, there is a need for increased personnel for training and administrative purposes, and a need for more adequate facilities including equipment to be utilized in these training programs.

II. LACK OF ADEQUATE DIAGNOSTIC FACILITIES

Lack of adequate diagnostic facilities in examining children who present multiple problems so that proper recommendations for educational placement may result.

The team needed for this project would include a psychiatrist, a psychologist, a social worker, and a secretary—as well as members of various medical and teaching groups concerned. The problem of differential diagnosis is a very important one. We have found that final and proper educational placement can sometimes be made only after trial in a group. Teachers' opinion helps to clarify some elements of diagnosis. A pilot study (class) should be set up as a part of this project.

There has been a noticeable growth in the number of atypical children—one of whose problems may be deafness. Some of the reasons for this increase are:

(a) Rate of infant mortality has declined during the last 50 years. Formerly 90 percent of children who contracted meningitis died. Now more than 90 percent live but, due to chemotherapy, these children may have many difficulties. Twenty years ago the RH factor was unknown. Now these children live and are found to be brain-damaged, aphasic, deaf, or have other problems.

Anoxia at birth: These children are often not responsive to sound at an early age. Later they may or may not be able to perceive or conceptualize. Superviruses cause central damages. Some children learn to inhibit sound because it is not meaningful. There may be no damage to hearing mechanism in these cases.

(b) Tremendous increase of knowledge of auditory system.

(c) Many revealing developments in measuring.

A basic question is not how much they hear but how they hear. If trained early enough with hearing aids, they may become hard of hearing rather than deaf. Insulation of nerves may change with proper and early stimulation. It is difficult to distinguish between disfunction and retardation.

Money should be made available for research with the rapidly growing number of atypical children throughout the country.

Many such children apply for admission to my organization. My concern is to find out just what is the problem, and whether there is an education program to fit their needs.

III. PILOT PROJECT IN PREVOCATIONAL TRAINING AND TESTING

A program to determine the job potential of aphasic, mentally retarded deaf, and others with special problems. This would involve an exploratory training program in various vocational areas on a very elementary level. The New York State Division of Vocational Rehabilitation will undertake the training of the handicapped if we can tell them in what areas there is a possibility of success. This should be considered a laboratory not just a special study.

Any results obtained from such a project would benefit students with similar handicaps in other parts of the country. New York City is an ideal place to carry on such an experiment because of the numbers of students available in a large metropolitan area.

IV. REGIONAL CENTERS FOR ADULT DEAF

There is great need for centers to be set up in areas throughout the country where deaf adults may go, or may be referred, for help in a large variety of areas other than vocational training which is ably handled by the division of vocational rehabilitation. These regional centers should be equipped with personnel to handle psychological, matrimonial, religious, legal, housing, communication, unemployment, social security, and all informational questions related to the deaf.

Such regional centers might well be a vital part of the bill H.R. 3465 (86th Cong., 1st sess.), pointed toward assisting handicapped persons to achieve independent living.

Our organization receives requests continually from former students, parents of former students, the general public, divisions of the New York City Board of Education, and outside agencies for information.

A few examples of recent, simple, but vitally necessary, information follow:

1. Visit from a parent of a former student who stated that she had awakened her son daily so he would get to work on time. Now he is to be married to a deaf girl. How can he be awakened on time?

We told her about various devices, such as an alarm clock with an attachment to the bedspring. When the alarm goes off, the bed shakes until the alarm is turned off.

2. Request from a district superintendent in Brooklyn for someone to be present at a hearing of a delinquent, vocational high-school student, to be held this current week. The parents of the boy are deaf and it is necessary for someone to see that they understand the charges, and be able to communicate their testimony.

3. A telephone call from a hospital seeking help. A deaf mother is returning home with her new baby. If the baby cries, especially at night, the mother will not hear it.

We explained that there is an electronic device consisting of a microphone attached to the baby's crib with a wire strung to a lamp which shines on the mother's bed. When the baby cries, the lamp light up and continues to flash. The cost is \$60. In cases of need, the regional office should be able to provide such equipment.

Thank you for the privilege of testifying.

Mr. ELLIOTT. Our next witness is Dr. Paul H. Hoch, commissioner, Department of Mental Hygiene, State of New York.

Dr. ELLIOTT. Dr. Hoch wrote you a letter stating that, because of the departmental budget hearings this afternoon, he could not be here, but he asked me to come representing the division.

Mr. ELLIOTT. And what is your name, please?

STATEMENT OF DR. HELEN ELLIOTT, DEPUTY ASSISTANT COMMISSIONER, DIVISION OF MEDICAL SERVICES AND RESEARCH, ON BEHALF OF DR. PAUL H. HOCH, COMMISSIONER, DEPARTMENT OF MENTAL HYGIENE, STATE OF NEW YORK

Dr. ELLIOTT. I am Helen Elliott. I am deputy assistant commissioner, Division of Medical Services and Research, Department of Mental Hygiene, State of New York.

Mr. ELLIOTT. You may proceed, Dr. Elliott. If you will summarize your statement, we will appreciate it. That will be with the understanding that it will be made a part of the record in full.

Dr. ELLIOTT. I will be glad to send it later.

Since the Department of Mental Hygiene of New York State may be considered as an operation in psychiatric rehabilitation, this hearing of the Subcommittee on Special Education we consider of vital importance to us.

The problem of rehabilitation is perhaps more prominent in connection with psychiatric disorders than in many other areas of medical practice, on account of the multiple practices involved and the various symptom complexes with their mental and emotional items, which often endanger a sense of rejection and social stigma on the part of both the public and the patient.

Rehabilitation is implicit in the goals of the treatment program of the department of mental hygiene. This is implemented by an orientation throughout all our personnel to the concept that the activities are directed to returning the patients to the community as an active participant in the functions of society.

The program must be sufficiently comprehensive to cover every age group, practically every type of problem, and at the same time flexible enough to meet the needs and potential assets of the individuals treated.

The Rehabilitation Act of 1959 would provide for the furtherance of this purpose in areas of unusual concern to us. Specifically, at present, a considerable number of the 560 adolescents in the age group

16 to 19 who annually are placed in the community from the mental hospitals in the department of mental hygiene and the 250 in the same age group who are released from the State schools and hospitals for the retarded, often enter society under handicaps and encounter difficulties and hindrances in their adjustment that result in social maladjustments requiring reinstitutionization.

It is our opinion that this should be evaluated fully to its conclusion to solving the problem of this group and of the much larger group of the young psychiatric problem cases in the community.

Such a pilot program would include community-based sheltered workshops, day care centers, vocationally oriented, and halfway houses for brief residential care, all with integrated psychiatric services.

Such resources, separate as to physical plants but identical and appropriate psychiatric services, should be also provided and available for the mentally retarded educable in the community, and the delinquent in this age group. Thus, for those groups, there would be provided a way to economic and socially responsible citizenship.

The inclusion of the latter group, the delinquent adolescent, is an expression of our concern for those of this age group who have given indications of a social ill and the precursor in our department for such service is our present services to the Department of Corrections, New York State.

With the purpose of preventing institutionalization of retarded individuals in the employable age group, a particular need is service for rural and semirural areas in the establishment of occupational training centers to provide model short-term training, under psychiatric supervision.

These should be in conjunction with community residential facilities to provide maintenance during the time the individual is away from home. Their establishment in national centers of the population of the areas served is recommended.

There appears to be a need for a more extensive program of vocational rehabilitation integrated with the program of in-patient psychiatric services.

This also needs critical evaluation and might well develop as a greatly extended system of sheltered workshops and vocational counseling and rehabilitation.

Preliminary experience has already been had with sheltered workshops in our department. Two of these are at present in operation in State mental hospitals; that is, within the hospital, and enabling legislation for the establishment and maintenance of sheltered workshops in State institutions, for the department of mental hygiene, is contained in chapter 394 of the New York State laws of 1959.

The sheltered workshop at the Manhattan State Hospital was set up under OM-228, of the Department of Health, Education, and Welfare, National Institutes of Health, to the research division of the Manhattan State Hospital, and is designed to evaluate by scientific study the influence of meaningful work on the patient's hospitalization and subsequent course.

These initial ventures provide a baseline for our suggested projects.

Prominent in any consideration of services for former mental hospital patients living in the community are those persons whose adjust-

ment is tenuous, due to factors of environmental and economic stress. These are usually concentrated in the large cities, and statistically there are one-quarter to one-third more women than men in this category. Their need for vocational evaluation and training services is urgent and vital.

Of deep concern are those of the 17,000 patients who are convalescing in the community at any one time from our hospitals.

The division of the research unit at the Manhattan clinic has an ongoing study under grant No. SP-176 from the Office of Vocational Rehabilitation, and this is relevant to the subject. In the report of the director of interim program, it showed that 28 percent of the patients in this study met the criteria for referral to the division of vocational rehabilitation. It is thought that 7 percent of all released patients could benefit materially by the establishment of a halfway house, to relieve environmental pressures which militate against their adjustment to competitive employment and community living.

The pattern under which this study has been set up in the Manhattan clinic is illustrative of the close and continuing collaboration of a representative of the division of rehabilitation, and the treating psychiatrist is one that might well be duplicated in other proposed projects.

To determine the most effective ways of using the techniques developed and the knowledge gained by the proposed pilot programs, it is essential that each pilot project design have ability in measure of its merit, including its applicability to all areas of the State as well as efficiency and economy.

Through the provisions of the Community Mental Health Services Act of New York State, which provides for the granting of State aid for approved mental health services, psychiatric rehabilitation services may be developed, expanded, and evaluated under local auspices.

The department of mental hygiene deeply appreciates the opportunity to testify at this hearing, especially so if the bill is enacted.

The psychotherapeutic techniques in use in the department may be well agumented by the gains made in the range of the pilot program.

Thank you, gentlemen.

Mr. ELLIOTT. Thank you very much, Dr. Elliott.

Our next witness is Dr. M. Schmideberg, director of Clinical Services Association for Psychiatric Treatment of Offenders.

If she is not here, our next witness will be Dr. S. Zwerling, Coordinating Council of the First District Branch of the Medical Society of New York City.

Dr. Zwerling, you may proceed.

STATEMENT OF DR. S. ZWERLING, DIRECTOR, COORDINATING COUNCIL, FIRST DISTRICT BRANCH, COUNTY MEDICAL SOCIETIES OF GREATER NEW YORK

Dr. ZWERLING. Mr. Chairman, committee members, it is a privilege to appear before your committee as a representative of the Coordinating Council of the County Medical Societies of Greater New York.

I fear that my interest in the subject far exceeds my professional abilities. However, I would like to state the position of the physician at large, and particularly the otologists, pediatricians, and psychia-

trists. We are increasingly interested in the education and rehabilitation of the hearing handicapped, and indeed in the early detection of hearing impairment. With equal interest we appear before this committee for help in maintaining the facilities now available and increasing the facilities to meet the needs where speech and hearing centers are not available.

Our interest today lies in the patient who comes to us with an irreversible hearing loss—the patient who requires education and the all-over problem of rehabilitation. Although there are facilities available in the New York area which provide these services, these centers and agencies are overtaxed in every department.

At the New York League for the Hard of Hearing the waiting list for hearing aid consultations, for example, is never less than 3 months, although in special instances our hearing aid consultant will stay overtime in cases where a job depends on a properly fitted hearing aid.

Many physicians have very frankly stated that they would be more interested in the examination of these children and adults if they had facilities available where their patients could be referred, and this with a minimum amount of travel.

The facilities available to us as physicians have long waiting lists. This applies to both public and private schools, institutions, and organizations alike. Since we suspect that about 1 in 10 persons has some degree of hearing impairment, we at once have large numbers of children and adults who may need the services offered by these various agencies.

I have a copy here of the Greater New York Council of Agencies for the Hearing Impaired which I will leave with your committee.

We are all aware of the growing public and professional interest in the hard-of-hearing individual and the significance of the hearing loss not only to the individual but also to the community. Hearing impairment is a public health problem because of its many facets, its implications, and the great number of people affected by hearing loss.

We are more conscious than ever before of the need for compensatory education for the hearing impaired individuals. We find that more and more people are asking for advice, information, and help on this subject. As an otologist who has been interested in the problems of the hard of hearing for many years, I feel that the facilities for the hearing impaired, particularly those for children, might be better distributed, populationwise, geographically, and also in the sense of their requirements. Therefore, I believe that Government subsidy for present resources is indicated, particularly for the medically indigent.

Only recently I received a "thank you" letter from the mother of two of my little patients, thanking me for sending in my report to the local school requesting lipreading instruction for these two little girls. The mother stated in her letter that as a result of my contact with the school, a lipreading teacher was hired. This is a very fortunate situation for there are many local school systems which make no provision for the hiring of special teachers.

On the other hand, trained personnel would be hired in some areas where such teachers are available. By "trained personnel," I mean public school physicians, speech-and-hearing therapists, teachers in remedial reading, and other areas. At the present time requirements in this

field of education are fairly high. A master of arts degree, with its consequent extra years of study, is almost obligatory and minimal. In some situations a Ph. D. is a requirement. A solution to this lack of trained personnel would be the provision of scholarships for young people interested in the field.

I believe that in some places the school cannot acquire or expend funds unless there are a specific number of children in the school who require special help. For example, I am informed that there must be more than five hearing-impaired children in a school of 1,000 pupils to justify hiring a speech-and-hearing therapist. As a physician, I cannot imagine having a child wait who needs help until four other children join him in his trouble, whether it be a matter of vision, cardiac, or malnutrition. There must be a way around this.

Could there not be Federal help given in the form of a subsidy for teacher, materials, and space needed for special education for even one child (such as that granted by the Smith-Hughes Act for home economics)?

There appears to be a lack of coordination among the governmental departments dealing with the needs of the hearing impaired. At present there are at least three departments concerned in this matter, whether it be education, provision of hearing aids, or vocational training. Perhaps this committee could recommend the appointment of a coordinator who would have the authority and funds to ease the way for the hearing-impaired individual. There appears to be a lack of centralized information between not only Government agencies but also between individuals agencies, and schools dealing with our hearing-impaired population. One might say that this is a matter for private or individual effort. On the contrary, however, the Federal Government and public health authorities surely would be in the most favorable position to collect and disseminate this information on request.

Another specific area in which the Federal Government could solve a present need is that of financial assistance to old people—and I am referring to the needs for hearing aids and the cost of upkeep. There is no reason for people on old-age assistance to worry about a hearing aid. They will be better, happier, and more able citizens with a well-fitted hearing aid. At the present time, no one on the subsistence pay allowed by OAA could possibly afford to wear a hearing aid.

Mr. ELLIOTT. What does a hearing aid cost?

Dr. ZWERLING. It varies anywhere from \$100 to \$250, up, depending upon whether it is one ear or both ears.

The problem of noise poses an occupational hazard. It appears that there ought to be uniform legislation for the prevention of occupational hearing loss.

The value of lipreading, scientifically taught, cannot be overestimated. I recently saw a patient who came in complaining that his hearing aid was not functioning properly. On checking the situation, the fault lay with the patient and not the aid. He had reached the stage where amplification was of no help, and this because of the progressive deterioration of his hearing. How did we communicate? By writing. Had this man had facilities for lipreading instruction, his problem would not be as catastrophic.

I know from experience, particularly with our local otologists and pediatricians, that they would be more interested in the problems of the hard of hearing and more cooperative if they had adequate facilities for diagnosis and followup for their hard-of-hearing patients.

The otologist, too, requires facilities for consultation, particularly in arriving at a diagnosis qualitative and quantitative, and this especially in his very young patients.

We need more teachers. We need more workers in the field who will receive an adequate salary as compensation, not only for their labors, but also for their heartaches. Our workers are dedicated men and women who are woefully underpaid and who receive less benefits than do the dishwasher or laborer. Better salaries, better facilities, and more space would, indeed, be an added attraction for students in our field.

Hearing is perhaps our most important sense and, naturally, any marked interference with its functioning will produce difficulties in communication and in adjusting to our environment (Newby, "Audiology," p. 214).

Let us remember that hearing is the most important sense in acquiring knowledge. As an otologist, I ask for help for those dedicated people who come to our assistance when medical and surgical intervention are not indicated, thus building a better and happier group of hearing handicapped individuals.

We, therefore, respectfully appeal to your committee for assistance and support in order that we may maintain the facilities now available, and we plead that your committee approve increasing the facilities to meet the needs where speech and hearing centers are not available.

Thank you.

Mr. ELLIOTT. Mr. Lindsay has a question.

Mr. LINDSAY. Do I understand from your testimony that the Medical Society of New York wishes to go on record in support of Senate Joint Resolutions 494 and 316? Those are the aid-to-the-teaching-training hearing bills.

Dr. ZWERLING. Yes, sir.

Mr. LINDSAY. Does the same apply with respect to H.R. 3465, which is the Rehabilitation Act of 1959, the so-called independent living?

Dr. ZWERLING. Yes, sir; insofar as I know.

Mr. LINDSAY. The medical society takes the same position on that?

Dr. ZWERLING. Yes, sir.

Mr. ELLIOTT. Thank you.

Our next witness is Mr. A. D. Buchmueller, executive director of the Child Study Association of America.

Is Mr. Buchmueller here?

He is not here, I am informed.

Let me go back a moment. Did Mr. Loberfeld come in?

Did Mr. Cloud arrive? He is the superintendent of the New York School for the Deaf.

Did Mr. Tunney, secretary of the Department of Correction, State of New York, arrive?

We will go to Mrs. Shirley Kurs, of the Parents' Association, New York School for the Deaf.

Is Dr. M. Schmideberg present?

Is Mr. A. D. Buchmueller present?

Is Mr. Manual Kardonsky here, from the New York Association for Brain-Injured Children?

Is Dr. John Paul, chairman of the department of speech, State University College of Education, present?

Dr. Paul, you may proceed.

STATEMENT OF DR. JOHN PAUL, CHAIRMAN, DEPARTMENT OF SPEECH, STATE UNIVERSITY COLLEGE OF EDUCATION, GENESEO, N.Y.

Dr. PAUL. Mr. Chairman and members of the committee, this is quite a distinct pleasure to be able to appear here to represent our unit from the State University of New York.

Mr. ELLIOTT. It is a pleasure to have you. Where is the State University?

Dr. PAUL. Our university is at Geneseo, N.Y., about 400 miles up State.

Although I am appearing here as a representative of the institution and working there in a teaching and administrative capacity, I would like to qualify myself also as an expert witness in the area of speech pathology and audiology.

Prior to coming here, I was director of speech pathology at the University of Alabama Medical Center, and prior to that the director of the training program and clinic at the University of Mississippi, and before that the assistant director of the clinic at Purdue University.

In all of these positions, I have been concerned with other areas that are under consideration today.

I have served on the Professional Board of Aid to Retarded Children in Birmingham, Ala., and was adviser to the State chapter of that group, as well as being consultant to the cerebral palsy school there.

In Mississippi I was consultant to the State cerebral palsy state hospital and the state school for the deaf, among other organizations.

I would, first of all, like to note that in the 20-some years that I have been concerned with this field, it has been with a great deal of pleasure that I have seen the Federal Government taking steps to help overcome the increasing difficulties we are having in attempting to cope with the needs, particularly in the fields of speech and hearing.

Mr. ELLIOTT. Dr. Paul, what do you think about the mentally retarded bill we passed last year, but for which we just made the initial appropriation in the session of Congress just closing? We appropriated \$1 million, as you may know, to provide teaching fellowships.

Dr. PAUL. Yes, sir, this is a very helpful kind of thing. We do have a teacher training unit at Geneseo for training teachers of the mentally retarded. We are getting financial assistance and it is very helpful.

Mr. ELLIOTT. Is it your general idea that we ought to do something along that same line in these other fields that you are speaking to us about?

Dr. PAUL. Yes, sir. I think there are several other areas besides the mentally handicapped field in which direct support of the institution as well as the student can help considerably.

Mr. ELLIOTT. I did not want to get ahead of you, but I am interested in what you are saying.

You may proceed.

Dr. PAUL. In general, I think I must say that without some kind of additional assistance, we are going to be more swamped in the very near future than we are now with regard to the need for assistance in all of these areas.

I am not going to go into the facts and figures which you have already heard, but with the increased assistance from medical science, you know that more children are living with more difficulties today than ever before in history, and that along with our birth rate, which has jumped remarkably since World War II, we are having the very difficult situation of attempting to contend with a greatly increased demand for services, at the same time we are drawing from one of the lowest manpower pools we have had to face in recent years.

If you go back to the low birth rate year of 1933, that makes our people who are now in the doctorial training programs coming from this very low birth rate year, and yet trying to deal with a large number of children, particularly, for whom we need a great deal of service. Of course, we can come right on down the line with regard to those who are at the master's level now.

Mr. ELLIOTT. In which fields, Doctor, are the shortages the greatest?

Dr. PAUL. I could not give you comparative figures on all fields. I have a general notion of the shortages in other areas. The shortages I am most concerned with, of course, are those in speech pathology and audiology, that being my own professional area.

Mr. ELLIOTT. Discuss the shortage in that field a little bit, with specific numbers, if you would.

Dr. PAUL. With regard to House Joint Resolution 494, which I believe is the bill you introduced, the figures there, I think, are a very conservative estimate, both of the number of children who are involved and the shortage insofar as the trained personnel are concerned. The figure is just normally, insofar as incidence is concerned, or the figures compiled by Wendell Johnson for use at the White House Conference, a 6 percent incidence of speech handicapped people and 4 percent incidence of hearing handicapped people, which is the lowest defensible figure, not the highest. We cannot go below this figure. It makes a total of close to 10 percent. You cannot go below that figure and defend going any lower.

Mr. ELLIOTT. Is there much overlapping in those two fields?

Dr. PAUL. Yes.

Mr. ELLIOTT. What percentage?

Dr. PAUL. Insofar as the hard of hearing are concerned, over half are in need of speech correction. Of course, when you go in to the area of multiple handicaps, that has already been mentioned today, we have people who are cerebral palsied, hard of hearing and partially sighted with speech problems, and, of course, quite often mentally retarded.

The medical director of the largest center for taking care of epileptics in the country, if not in the world, told me that they were having a great deal of difficulty because they have good medical care, they have young people who are controlled as far as seizures are controlled,

medically, but they have no one to teach any of the children, they have no one in speech correction, no one to work with speech.

There are several shortages insofar as other professions are concerned than medicine.

I was very interested in hearing the remarks that Dr. Zwerling had to make concerning the needs that the medical profession is recognizing insofar as the consideration of other professions is concerned. It is something that has become more and more apparent.

I can assure you that my medical colleagues at Alabama shared this feeling 100 percent. I was in the department there in my professorial appointment.

The needs insofar as speech and hearing are concerned, as I indicated, I believe are rather conservatively stated because these figures were gathered some 5 or 6 years ago, and we have had, of course, our continuing increase of children getting particularly into the public schools where the need really becomes apparent and where we do our best job of case location.

But our needs go further than just the need for having rehabilitation personnel. It has been mentioned several times by several witnesses before this committee that we have the first problem of location, and then after location a very difficult problem of diagnosis, particularly for these multiple handicapped children, when you need the services sometimes of 8 to 10 specialists before you know what to do first or how to proceed after a certain amount of work has been accomplished.

The diagnostic end of our work, particularly in speech and hearing, which is my field, is one that I think is very often overlooked. This is an area in which I think this particular committee and its recommendations and consequent possible legislation, can be of a great deal of assistance. The money end, I think, is quite obvious, that in order to get an increase in personnel, many people need financial assistance. But more than that, the money that is needed to provide training facilities is quite considerable also.

One witness this morning mentioned that in order to train people in a highly skilled occupation or profession takes more trained people for the training than you need in order to give a lecture to a group of 40 or 50 students.

A study that we made while I was working with the Southern Regional Education Board on the Special Education Committee indicated that the better clinics throughout the South used a ratio of one instructor to every eight or nine students in speech and hearing clinics for their training program. This is, of course, quite different than the 1 to 25 ratio which is often used for classroom teaching purposes. But the financial end is very difficult in many institutions.

There is also, of course, the problem of staffing the present training programs. This is becoming an increasingly difficult job because of the need across the board for professionally trained people in hospitals, clinics, in speech and hearing centers across the country, so it is now getting difficult to obtain the professional services of well-trained, highly skilled people in speech pathology and audiology, who are willing to teach, because it not only is a matter of a shortage of people but the salaries are not as good as you can get in other places. So there is a difficulty of even staffing our training programs in existence,

much less expanding programs beyond those that already exist or building them up to a necessary level.

One point that I would like to make in support of one of the provisions of House Joint Resolution 494, with regard to training of speech pathologists and audiologists has to do with section 201, the sentence beginning on line 14 and ending on line 20, which has to do with national certification qualifications for the selection of training programs for support.

This is a very difficult problem locally in institutions of higher education; that is, State by State. In all the States I have worked in, I find that the State education departments set minimum standards, and they are confessedly minimum standards, and yet these minimum standards very often become the maximum standards for the training institutions for some of the reasons that have been mentioned previously.

So, going to a national professional certifying agency rather than depending upon local educational agencies, I think, is a very important way of encouraging the upgrading of training programs. In fact, I had one responsible certifying officer in one State department of education say he was not concerned with the American Speech & Hearing Association, which does certify nationally, that the difficulty was in getting someone out to take care of the children immediately, which I think is an evasion of a primary fundamental responsibility.

The upgrading of the training is one thing that I think should be encouraged whenever possible. This, would, I believe, serve to do that.

The principal point that I would like to make with regard to how I believe particularly Resolution 494 would help, quite apart from the financing end of things, is in the recruiting of students.

One thing I think that is very often overlooked by people who are not directly concerned with training programs is that, in order to get graduate training programs built up, we must draw from an undergraduate program. So, in order to get at the figures which are mentioned in this bill, which is to quadruple the supply of speech pathologists and audiologists today, that means that we must somehow recruit from an undergraduate program which, in itself, has an attrition rate of about 40 percent, from the time students start in until the time they are ready to go into graduate work. So the recruiting, as a factor in increasing the supply of professional personnel, has to actually reach down to the junior level in high school. This is what we are experiencing in our offices across the country. I have this from our director of admissions, that unless we get the people interested in a given field by their junior year in high school, they are already applying for admission to a given program and a given college when they are seniors. In fact, we are interviewing people right now for admission next fall, seniors in high school.

If we are going to draw from an undergraduate training program for speech correction, at the graduate level in 1 year's time, if we are going to train people to be competent diagnosticians as well as therapists, they must get a portion of that training in their undergraduate years.

That means essentially that to quadruple the number of well-trained highly qualified specialists at the graduate level, we have to

expand our undergraduate training programs also, perhaps to the tune of 6 to 8 times, if not 10 times.

My suggestion directly on this score is that smaller training institutions be encouraged to expand their training programs at the master's level rather than depending upon a few large institutional training programs across the country to supply the manpower we need.

Most institutions serve a rather restricted local area. So if we have many smaller, medium size and smaller institutions across the country recruiting in all of these areas, we will then have the feeders up to the graduate program which are necessary if we are actually going to get four times as many highly competent specialists as we have today.

Mr. ELLIOTT. Doctor, Mr. Daniels has a question for you.

Mr. DANIELS. Apparently you are familiar with House Joint Resolution 494, which recites that some 8 million Americans of all ages suffer from speech or hearing impairments and further recites there are some 20,000 speech pathologists and audiologists needed to train, diagnose, and rehabilitate them.

Are those figures a conservative estimate of the number of people in that field and the number of teachers, in your opinion?

Dr. PAUL. I think that the estimate of the number of people needing attention is quite conservative, provided you will admit the less complex, less severe cases, because, actually 10 percent is the figure that has been arrived at nationally through our national association as the number of people actually in need of trained assistance in both areas of speech and hearing.

So, out of the 180 million population, that means 80 million rather than 8 million.

For severe cases, yes; I would agree with that figure.

Mr. DANIELS. How many training centers do we have in the United States for the training of speech therapists and audiologists?

Dr. PAUL. That is a tricky question because you go into the matter of qualifications. If you accept local qualifications where in some States 6 hours' training is adequate, we have many. If we accept the national standards now being written into law by many State departments of education, you would reduce the number considerably.

Mr. DANIELS. Are the present facilities adequate for the training of the necessary personnel?

Dr. PAUL. No, sir. We seem to be losing ground rather than gaining right now.

Mr. DANIELS. Do you think the Federal Government is wise in looking into this area?

Dr. PAUL. I think not only wise but to be very much commended for doing so.

Mr. ELLIOTT. Are there any further questions?

Mr. GAIAMO. Assuming that the Federal Government does not get into this field, what plans are envisioned for trying to accomplish some of the results?

Dr. PAUL. Well, there are several of us who share my own feelings that the solution is building up smaller training programs in many locations across the country. Several of my colleagues are doing just that, have done exactly what I did, leave a strictly professional practice to go back into a training or educating function.

This is about the best we can see, except for grants from certain agencies. There are certain agencies that do help, such as United Cerebral Palsy, Society for Crippled Children and Adults. There are many agencies that will assist, but it is rather stopgap and temporary.

Mr. GIAIMO. Are the States becoming increasingly aware of the problem you are faced with?

Dr. PAUL. Yes; as the demand grows, particularly in the public schools, where I think most of the work really needs to be done, as the demand grows, the State administrations become increasingly aware. But by the time it trickles down to the local administrations in the institutions of higher learning we are still pretty far behind in trying to catch up.

Mr. GIAIMO. Thank you.

Mr. ELLIOTT. Thank you very much, Doctor.

I am told that Dr. M. Schmideberg, director, Clinical Services Association for Psychiatric Treatment of Offenders, is present.

You may proceed, Dr. Schmideberg, with the exception that we have to limit our witnesses to about 10 minutes.

STATEMENT OF DR. M. SCHMIDEBERG, DIRECTOR, CLINICAL SERVICES, ASSOCIATION FOR PSYCHIATRIC TREATMENT OF OFFENDERS

Dr. SCHMIDEBERG. My main point today is that we see a great number of juveniles, mainly over 16, who either cannot read or cannot read but at the second- or third-year level. Sometimes they can read and do not understand what they read, and alternatively they can read but do not know arithmetic. Ask them, "How much is 3 times 15?" and you get amazing answers.

I think some stress has been laid on reading disability, which is, to me, illiteracy, but not knowing arithmetic—what it means in practice, of course, is this: The only chance a boy has who cannot read or who does not know elementary arithmetic is to become a trucker's helper. He cannot even be a messenger boy.

So what happens to these boys?

I want to stress two things. These are not foreign-born. These are boys who are Americans, born here, or Puerto Ricans who have been in New York City for over 10 years, and they have normal intelligence. In fact, some of them are of superior intelligence. They have gone to school, they have even gone to high school, and somehow managed to get through school without really learning to read. It is hard to know how many are like that.

The training schools told me that, according to their statistics, 80 percent of their boys, and particularly those from the New York area, are below the fifth-year reading level, and their staff at the training school is so limited that they leave more or less as they were when they came in.

If somebody can read at all, they manage to get him to the second-year level, but not above. All organizations treat them as illiterates. They are usually on probation or parole, or sent to social agencies.

We have started now an auxiliary service of teaching them to read, to learn how to do some simple multiplication, and a minimum of

manners; by "minimum" I mean that that is necessary to get you a job, where they do not know how to apply for a job.

What it means is also this: If somebody is going through the school and has not learned to read, he is outside of civilization; he is different from others, which has a very bad psychological effect on him.

There may have been peculiar reasons why they did not learn to read; but whether or not, not having learned to read, sitting on the back bench or being unwanted at school, of course, has a very bad effect on their mentality.

Also, going to school and learning something is a preparation for the discipline you need to work later on. If they never have that discipline at school, if they never learned to read and write, or what used to be called the three R's, they are unable to be employed. Usually they are unemployed. A large number of them become delinquents.

What happens is that they hang around at lunch time. Because they have nothing to do, they go out and steal a car in the afternoons.

Some do not even have that initiative, but stay home and are burdens to welfare. They are the first people to lose their jobs if there is just a shade of a depression.

It seems to me it is important that something should be done. Apparently, the schools cannot help them, because a large number have been out of the schools. There are no facilities whatsoever for people over 16 learning to read and write.

It is also very hard to teach them. It is much easier to teach a small child and much easier to teach a foreigner. It needs a great deal of perseverance, patience, and understanding to teach them.

We have been trying in our organization, and we have also worked with various college men, and they have tried to do it. They go to the homes and they keep after these boys to get them to attend. There are great difficulties getting them to attend. We are trying to prevail upon the judges that it should be made a condition of probation that they learn to read. Some judges make it a condition and some do not.

I think there should be more publicity given to it and more should be tested.

It is a very frequent reason for not having jobs and not holding jobs.

I think in the present shortage there are practically no facilities, but there should be facilities.

In the meantime, I think we should enlist the citizens under professional guidance, trying to train boys and girls who do not know the most elementary knowledge.

That is all I have to say.

MR. DANIELS. In the State of New York, do you not have compulsory education?

DR. SCHMIDBERG. Yes.

MR. DANIELS. Are these children not obliged to attend school?

DR. SCHMIDBERG. Yes. They have compulsory education and go to school, but they manage to go without learning.

MR. DANIELS. If that is so, how do you account for the fact that the boys, 15 and 16 years of age, are totally illiterate?

DR. SCHMIDBERG. Because until 2 years ago they were advanced whether they could read or not.

Mr. DANIELS. These boys were permitted to remain in school being totally illiterate, unable to read, unable to do their arithmetic problems?

Dr. SCHMIDBERG. Yes.

Mr. DANIELS. And no program has been set up in the school system?

Dr. SCHMIDBERG. Well, some schools have remedial reading, as it is called, but it is quite insufficient for the demand.

Mr. DANIELS. Has any study been made, to your knowledge, as to the causes of these conditions that you find?

Dr. SCHMIDBERG. To my knowledge, no. But also I do not think a study has been made as to the extent of the illiteracy.

I think the first thing would be to establish the extent of it. I have only discovered it by asking the boys.

When you see them, they appear like anybody else, and you do not even have the idea they do not know how to read and write until you ask them the questions.

Mr. DANIELS. You have become cognizant of this problem by virtue of your position?

Dr. SCHMIDBERG. Yes.

Mr. DANIELS. What is your position?

Dr. SCHMIDBERG. I am director of the clinical services of the Association for Psychiatric Treatment of Offenders.

Mr. DANIELS. Where?

Dr. SCHMIDBERG. In New York City. That means we are treating offenders mainly referred by the courts but also by social agencies.

I believe that some court clinics are aware of it, but I do not think sufficiently.

Probation officers are usually overworked. I imagine the welfare officials are too overworked to inquire into people's abilities to read and write.

Actually, I do not think anybody ever thinks of it, because you just take it for granted that people can read and write, until you find out that they cannot.

So, it seems to me that the first step would be to find out what percentage it is. The training schools are aware of this to some extent.

Mr. DANIELS. What percentage of the pupils referred to your agency by the court do you find in the category you have described here today?

Dr. SCHMIDBERG. Of the juveniles, it is a large percentage. I do not think I could give it percentage-wise because we only take a limited number.

Mr. DANIELS. Suppose we try to arrive at it in a different way. How many boys per annum are referred to your agency by the courts?

Dr. SCHMIDBERG. I would say about 200.

Mr. DANIELS. And of that percentage?

Dr. SCHMIDBERG. I would say about 50 of them have very poor knowledge.

Mr. DANIELS. About 20 percent?

Dr. SCHMIDBERG. Yes. The training schools give a much higher percentage. As I say, our agency is not representative because we are picking and choosing. But I think the probation officers could find out if they have the time.

The training schools have made studies and have arrived at the 80 percent figure, which is a very bad one, and they claim it is not being remedied because of the shortage of staff.

Mr. DANIELS. I have just one further question.

With reference to this delinquency problem, do you find that the children come from a certain area or strata of society, or would you say from all levels?

Dr. SCHMIDBERG. Well, I would say geographically they are all neighborhoods. Socially they are a poorer class. Maybe they can read, perhaps not well, but they do learn to read. But we have decent working class parents who themselves can read and whose children cannot.

Mr. DANIELS. Thank you.

Mr. GIAIMO. Is it your contention that these people are emotionally disturbed not because of psychiatric disorders of some type or mental illness, but because of the fact that they do not know how to read?

Dr. SCHMIDBERG. I think it is a vicious circle. It is a question of the hen and the egg. I think of somebody 3 months behind, but it is not picked up until he is 3, 4 and 5 years behind, by which time he is utterly disinterested because he cannot follow. He is out of civilization. The other children look down on him. He feels like an outsider in the school. It makes him antisocial. He does not participate in normal activities. He feels different and he is different. So it is a vicious circle.

The large proportion of them are likely to become delinquent, first, because they are different, and, second, because they are not likely to get a job or they will get a very, very poor job. Those who do not become delinquent I think become welfare cases. Those become emotionally disturbed.

Mr. GIAIMO. But you think that basically it is the disability to learn how to read?

Dr. SCHMIDBERG. And arithmetic, multiplication. They can do some arithmetic up to a point, but they do not know the multiplication table except hazily. They cannot do multiplication, they cannot do subtractions, and divisions I do not yet ask anybody to do.

Mr. GIAIMO. What is your proposal to the committee?

Dr. SCHMIDBERG. I think it should be directed to all levels. The schools should be given more help.

Mr. GIAIMO. To teach them to read or to find out why they cannot learn to read?

Dr. SCHMIDBERG. To give those who are behind extra tuition. The training schools, almost all of them, are behind and need more staff to teach them. I think the college and welfare agencies should be alerted to the needs. I think a survey should be made as to the extent of this illiteracy.

Mr. GIAIMO. Do you think the illiteracy is just because of the fact that they are not getting special instructions?

Dr. SCHMIDBERG. Well, having been 10 years behind your peers.

Mr. GIAIMO. Do you think if they had this special instruction, they would be able to read?

Dr. SCHMIDBERG. At the proper time. The later you give it, the harder it is to give it, the more they have to adjust.

I think the courts also should use their powers. I think any agency that gets in contact with this type of population should use as much power, persuasion, and, if possible, other power, but also provide facilities. I think you should be giving individual instruction. I do not think you can give it in class any more because they are too difficult. They must be very, very small classes, maybe four or five.

Mr. GIAIMO. Thank you.

Mr. ELLIOTT. Thank you very much, Dr. Schmideberg.

Let me call the list again. Has Mrs. Shirley Kurs arrived?

We have a telephone call that Mrs. B. Scher will not be here.

Is Mr. A. D. Buchmueller here, from the Child Study Association of America?

Is Manual Kardonsky here?

STATEMENT OF MANUAL KARDONSKY, PRESIDENT, NEW YORK ASSOCIATION FOR BRAIN INJURED CHILDREN

Mr. ELLIOTT. Mr. Kardonsky comes to us from the New York Association for Brain Injured Children.

Mr. Kardonsky, will you do your best to summarize in 10 minutes?

Mr. KARDONSKY. Mr. Chairman and members of the committee, I am glad to see under your bill H.R. 3465, under the facts and declaration, you have a finding that there are many severely handicapped persons, and then you include "including the mentally ill or retarded." I am glad to see that, that you have these categories. But as a representative of an organization for brain injured children, I wish that you would include an additional phrase "or brain injured" in that particular area.

By "brain injury," medically speaking, we know that it is any damage to the brain, whether it is prenatal or postnatal.

I submit to the committee a brief résumé of talks by Dr. Lawrence Taft, who is from the Department of Pediatrics of the Albert Einstein College of Medicine, a definition of brain injury, a diagnosis, the causes and the treatment.

Mr. ELLIOTT. Without objection, that statement will be made a part of the record.

(Material part of committee file.)

Mr. KARDONSKY. What I would like from the committee is that you would please include the problems of the brain injured in your thinking, in your planning.

For instance, in New York State, in the Department of Education, and in New York City in the Board of Education, brain injured children are considered to be physically handicapped. From this, they are presumed to derive certain benefits under certain laws.

In your rehabilitation or habilitation of persons, if you would aid them and perhaps follow on through on the thinking that the State of New York uses, we can derive benefits for brain injured children.

What are the main problems or what is the main problem of brain injured children? It is that they must receive education. It is one of the greatest crimes in New York City, in New York State, that you cannot find too many teachers to teach the brain injured children, and you turn around and have a vicious cycle. Because there are no

classes, there are no teachers studying for that field. Because there are no teachers studying for that field, there are no classes.

I would suggest for your consideration that you find, through some of your teacher training grants, ways and means of implementing the funds available for such teacher training, as small as they might be. For instance, in New York City, the board of education grants sabbatical leaves of absence wherein the teachers who take such leaves may use it for study, for educational purposes, for travel, or what have you. They receive up to 40 percent of their salary.

We in New York City, and also in Westchester, allocate from our meager funds \$1,000 for each of the two communities toward the teacher training grant, but we find that no teacher is willing to take the \$1,000 per annum as the basis of their annual salary.

If we can find some institution, or the congressional committee or some fund agency, to make up the difference to these teachers, we will find that there will be teachers willing to study for this particular field.

Gentlemen, if you take that into consideration as a beginning, I think that is doing something for the children who are brain injured.

Mr. ELLIOTT. Thank you very much.

Mr. DANIELS. Your recommendation, then, is a **direct grant to the student?**

Mr. KARDONSKY. Whether it is to the State—some means so that a student may get a grant. For instance, in New York State they have grants for cerebral palsy. If you have an additional grant in the State of New York for brain injured children, as such, we can then have teachers come into our field.

I will give you an example in New York City. They want to open a class. What do they do? They scout around for a teacher who may have some training and they will take her out of, say, a cerebral palsy class or a mentally retarded class or a health class, and say to her, "Teach."

What happens is that if she is willing and has the heart for it, she will grow as the children grow. She will learn how to handle these children as the problems come up before her. If she knows where to turn to for supervision, she can really get some good aid in that sense.

We, as an organization, have several avenues where teachers can train in New York City and in Westchester. The only trouble is we do not have the funds for the teachers so that they can spend full time training. We feel that if they would train for 1 year they could be adequately prepared to handle our children.

Mr. DANIELS. Where are these training centers that you refer to?

Mr. KARDONSKY. There is one at the Stephen Wise Synagogue in Manhattan here on West 68th Street, specializing in brain-injured children.

Mr. DANIELS. Are there any others?

Mr. KARDONSKY. There is another one called the Lottie Kolinsky School, on West 77th Street. There is also in Westchester a school in Pelham. These are three centers which are outstanding in the handling of brain-injured children.

Mr. DANIELS. Thank you.

Mr. ELLIOTT. Thank you very much.

Our next witness is Dr. B. Siegenthaler of the Speech and Hearing Clinic, of the Pennsylvania State University.

STATEMENT OF DR. B. SIEGENTHALER, AMERICAN SPEECH & HEARING ASSOCIATION

Dr. SIEGENTHALER. Although I am at the Pennsylvania State University as an associate professor of clinical speech, I am here today representing the American Speech & Hearing Association.

For over 30 years the American Speech & Hearing Association has been active studying the causes of and treatments for problems of speech and hearing. Members of the association have been and continue to be interested in the magnitude of the problems, as well as in the professional training of speech pathologists and audiologists. The association has a continuing program of certification for its members, who represent the professions of speech pathology and audiology in America. This certification program, especially at the advanced level, indicates the presently acceptable competence for well-qualified professional speech pathologists and audiologists.

The intent of the following is to indicate the prevalence of speech and hearing problems according to studies by members of the American Speech & Hearing Association, as well as studies by other persons and agencies, and to support efforts to increase the number of adequately trained speech pathologists and audiologists.

Prevalence of speech and hearing problems: It is convenient to subdivide the information that follows into several sections. In essence, we are speaking of the legislation as exemplified in House Joint Resolution 494. For clarity and convenience I have divided the following information into several subsections.

In all instances the final prevalence figures are based on the predicted continental United States, Alaska, Hawaii, and Puerto Rico population for 1960.

Speech problems among children 5 to 19 years of age: The data on incidence of speech problems among children vary somewhat, but an attempt was made to arrive at an incidence figure which, all factors taken into consideration, gives a relatively conservative estimate of the magnitude of the problem. For the present purposes 5 percent was used as the incidence of speech problems among schoolchildren. The publication, Statistical Abstracts of the United States, 1959, 80th edition, U.S. Department of Commerce, Bureau of the Census, indicates that in 1960 there are expected to be 49,782,000 children between the ages of 5 and 19 years in the United States, excluding Alaska, Hawaii, and Puerto Rico. If the incidence of 5 percent is applied to this population, 2,489,100 children of school age are expected to have speech problems in 1960. This does not include children with hearing problems.

A number of specific aspects of the data are of interest. For example, in 1959, Ohio had 79,688 school age children with speech problems. Of these only about 30 percent were receiving corrective therapy, largely because of the lack of trained therapists. Cerebral palsy, a neurological disorder which frequently causes speech problems, afflicted between 75,000 and 125,000 children living in the United States in 1947.

In 1953, there were 306,743 children in special education classes specifically because of speech disorders.

In 1946, there were 1,134 cleft-palate children living in the State of Wisconsin.

These figures, although fragmentary and somewhat out of date, give a few details of speech problems among school age children.

Speech problems among children under 5 years of age: There are no comprehensive studies available regarding incidence of speech problems among children under 5 years of age. However, a number of conditions causing speech problems are present at birth. Both cerebral palsy and cleft palate are of this type, and the incidence of cleft palate and cerebral palsy would be expected to be as great among preschool children as among older children. Stuttering typically has its onset during the preschool years. Other speech problems, such as articulation defects, also have their onset during the preschool years, but they are more difficult to diagnose at that age.

Cerebral palsy occurs in about 0.07 percent of the live births, and the rate of cleft palate is about 0.18 percent among live births. If these two figures are applied to the estimated 21,019,000 of children under 5 years of age predicted for the United States in 1960, it is expected that 52,457 children under 5 will be suffering from these 2 afflictions. In addition, a very conservative estimate would be that an additional 1 percent of the children under 5 years will have other types of speech problems. This percentage would produce 210,190 additional children with speech problems.

Thus, it may be predicted that in 1960 there will be an estimated 262,737 children of preschool age with speech problems living in continental United States. This does not include children with hearing problems.

Speech problems among adults: As with incidence studies on children, the data on adults vary somewhat from study to study. Studies, in which trained speech therapists examined the sample of populations considered, have reported the incidence to be as high as about 5 percent. Inasmuch as speech pathologists have the effect of reducing the prevalence of speech problems among the patients they treat, the incidence of speech problems among adults may be expected to be somewhat less than among children. However, a countereffect is that stroke, traumatic injuries, and removal of the larynx as a treatment for cancer are more common among adults, especially among the older citizens than among children. In view of these counterbalancing factors a 3-percent incidence is reasonable for speech problems among the adult population. The estimated U.S. population over 19 years of age is 110,353,000 in 1960, excluding Alaska, Hawaii and Puerto Rico. Thus, it is estimated that there will be 3,310,590 adults in the United States with speech problems in 1960.

Some specific data are of interest. Among the 170 Veterans' Administration hospitals it is estimated that 1,500 veterans per year are admitted because of stroke, which commonly produces aphasia. In the State of Pennsylvania alone, during a 6-month period in 1958, 92 persons were operated on for cancer of the larynx. At this rate there are at least 1,108 laryngectomies performed in the United States each year.

Speech problems in Alaska, Hawaii, and Puerto Rico: The bulletin, "Bureau of Census Current Population Reports, Population Esti-

mates, February, 1959," gives the 1957 combined population for Alaska, Hawaii, Puerto Rico as 2,990,000. Allowing only a 10,000 increase in population for these areas by 1960, and utilizing the same overall rate as found for the continental United States, namely, 3.4 percent, an estimated 102,000 persons of all ages may be expected to have speech problems in 1960 in Alaska, Hawaii, and Puerto Rico.

Hearing loss among school age children: The results of a number of recent surveys suggest that the incidence of hearing loss among school age children is about 3 percent. Thus 1,493,460 school age children may be expected to have some reduction in hearing acuity in 1960, within the continental United States.

However, many of these children will have mild losses, or losses limited to one ear which do not necessarily result in education handicaps. The incidence of significant or handicapping hearing loss is about 7 percent among the U.S. population between the ages of 5 and 19 years. Thus 348,474 school age children may be expected to have educationally significant hearing problems in 1960, excluding Alaska, Hawaii, and Puerto Rico.

Hearing loss among children under 5 years of age: Among preschool age children the incidence of handicapping hearing loss is expected to be lower than among older children. Although many children are born with hearing loss which remains throughout their lives, others acquire hearing loss after becoming of school age. For purposes of the present report a somewhat arbitrary figure of 3 percent was chosen to estimate the number of hearing handicapped children of preschool age. When this incidence figure is applied to the estimated 21,019,000 children of preschool age for 1960, it is to be expected that 63,057 children under 5 years will have significant hearing problems, excluding Alaska, Hawaii, and Puerto Rico.

Hearing loss among adults: Among the adult population the incidence of significant hearing loss is believed to be greater than the incidence of significant hearing loss among children. This is true partially because hearing acuity undergoes progressive reduction as a function of age. Thus the older segment of our population has a relatively high incidence of handicapping hearing loss. It has been estimated that as of 1959 there were 2,302,700 hard of hearing and deaf persons over 15 years of age in the United States. This is an incidence of 2.1 percent. Applying the 2.1 percent incidence to the estimated adult population in 1960 gives 2,317,413 with significant hearing problems in the continental United States.

Some data on specific segments of our adult population are of interest. For example, at the present time there are 90,000 veterans receiving either compensation for "service connected disability" or "pensions" because of hearing loss. During the years 1954 through 1958 the bureau of rehabilitation in Pennsylvania brought to successful closure 1,952 clients who either had deafness or handicapping hearing losses.

Hearing loss among Alaska, Hawaii, and Puerto Rico:

According to the previous computations, 1.5 percent is the overall incidence of handicapping hearing loss among the population residing on the mainland. If this same incidence figure is applied to the estimated 3 million total population of Alaska, Hawaii, and Puerto Rico, there will be an estimated 45,000 individuals with handicapping hearing loss in these areas in 1960.

Summary of speech and hearing problems in United States and Puerto Rico: If all of the previously obtained data are summed we find that there will be an estimated 6,164,427 individuals with speech problems, and an estimated 2,773,944 individuals with handicapping hearing problems in the United States in 1960. The grand total of these figures is 8,938,371, the estimated speech and hearing problem population of this country in 1960. These nearly 9 million American citizens with speech and hearing problems represents what is believed to be a relatively conservative estimate which does not take into account the probable increase in the proportion of our population over the age of 65. As indicated earlier, this older part of our population may be expected to have an increased rate of handicapping hearing problems as well as an increased rate of certain types of speech problems.

Attached to this manuscript is a summary of the incidence and prevalence figures mentioned earlier in this report.

(The figures referred to follow :)

Estimated incidence and prevalence of speech and hearing problems among U.S. 1960 population (continental United States, Alaska, Hawaii, and Puerto Rico)

	1960 population	Incidence, speech problems	Prevalence, speech problems	Incidence, significant hearing problems	Prevalence, significant hearing problems
		<i>Percent</i>		<i>Percent</i>	
Under 5 years (continental United States).....	21, 019, 000	1.3	262, 737	0.3	63, 057
5 to 19 years (continental United States).....	49, 782, 000	5.0	2, 489, 100	.7	348, 474
Over 19 years (continental United States).....	110, 353, 000	3.0	3, 310, 590	2.1	2, 317, 413
Alaska, Hawaii, and Puerto Rico (total all ages).....	3, 000, 000	3.4	102, 000	1.5	45, 000
Total.....	184, 154, 000	-----	6, 164, 427	-----	2, 773, 944
Grand total (speech and hearing).....	-----	-----	8, 938, 371	-----	-----

Dr. SIEGENTHALER. Personnel needs for adequately serving the population with speech and hearing problems: The successful habilitation of persons with speech and hearing problems requires the services of well qualified professional speech pathologists and audiologists. Good practice suggests a caseload of not more than 100 children per therapist in a public school speech and hearing program. The approximately 2,500,000 children of school age with speech problems indicates the necessity for 25,000 public school therapists. The office of vocational rehabilitation has estimated the need for one speech pathologist and one audiologist per 50,000 population in addition to public school therapists providing a strong speech and hearing program is operating in the schools. To meet the needs of the general population 7,366 speech pathologists and audiologists will be required as of 1960. Thus, a total of over 32,000 professional, competent people are required to meet the needs of our population with speech and hearing problems.

Mr. ELLIOTT. Is that 32,000 in addition to what we now have?

Dr. SIEGENTHALER. This is including the present approximately 7,000.

Mr. ELLIOTT. We have a shortage, according to your testimony, of about 25,000?

Dr. SIEGENTHALER. Something of that order at this moment.

This large number of appropriately trained speech pathologists and audiologists is in sharp contrast to the present supply of about 2,000 certificated and 5,000 noncertificated persons in the speech and hearing field.

Mr. ELLIOTT. Is that the 7,000 you mentioned?

Dr. SIEGENTHALER. Yes.

Mr. ELLIOTT. Only 2,000 of the 7,000 are certificated?

Dr. SIEGENTHALER. That is correct, at any level in the American Speech and Hearing Association. I am speaking in favor of the advanced level of certification.

To attempt to supply the Nation with over 32,000 professional personnel in speech and hearing within the immediate future is obviously unrealistic. The professional preparation of a speech pathologist or audiologist is rigorous and time consuming. The training must include academic work specific to speech and hearing problems, comprehensive clinical practicum or internship, training in cognate and ancillary fields, and at least some research orientated experience. To specify less in the professional preparation of speech pathologists and audiologists would produce persons incompetent to serve the needs of our speech and hearing problem population.

If we set an exceedingly conservative goal of only 20,000 professionally trained personnel for 10 years from now, we must train speech pathologists and audiologists at the rate of 1,500 per year. The training of 1,500 per year would result in 15,000 over a 10-year period. This 15,000, added to the present 2,000 certificated and 5,000 noncertificated personnel would result in a total of 22,000. By allowing a 10 percent loss through marriage and so forth, there would be 20,000 remaining. Thus, if we wish by 1970 to obtain only 20,000 professionally trained personnel to meet the needs of those with speech and hearing problems, we must immediately begin to train at least 1,500 well-qualified speech pathologists and audiologists per year.

The 1,500 figure is markedly different than the 400 persons currently being trained in the speech and hearing field each year. The problem is even more acute when we consider the shortage of university personnel needed to train the future speech pathologists and audiologists. In 1956 only 34 doctorate degrees in speech pathology and audiology were granted. In 1957 the number had increased to 37.

The national professional body, the American Speech and Hearing Association, lists 30 schools training at the Ph.D. degree level and 40 at the masters degree level. To provide each of these training centers with additional staff and equipment to upgrade and expand training facilities would require on the average (based on Office of Vocational Rehabilitation experience at the past 2 years) \$11,000 per school per year, or a total of \$770,000 per year. If support were to be provided for the training of one-third of the needed 1,500 personnel we must train each year, and if this support were to beat the current average of Office of Vocational Rehabilitation traineeships (approximately \$2,500 per year) \$1,250,000 would be needed annually for traineeships. The combined annual cost of the teaching grants to 70 schools and training grants to 500 trainees would come to a total of about \$2 million. At the present time this would appear to be the only feasible method to begin to secure the personnel prepared at

a professional level if we are to make useful taxpaying citizens of the millions of speech and hearing handicapped in the United States—most of whom are presently receiving no professional help with their handicap because of the desperate shortage of trained personnel in the speech and hearing field.

In closing may I express the appreciation of the American Speech and Hearing Association for this opportunity to present the above information to this committee. May the Congress as well as other governmental bodies be assured that the American Speech and Hearing Association stands ready to serve in whatever way it can the needs of these citizens who have speech and hearing problems.

Mr. ELLIOTT. Thank you very much, Doctor.

Our next witness is Miss M. E. Tuttle, director of the vocational advisory service.

Is Miss Tuttle present?

If not, I will call the list of those who have been absent. Mr. Loberfeld? Is Mr. Bluestine here? Mr. Cloud? Mrs. Kurs? Mr. Buchmueller? Mr. Buchmueller is here.

STATEMENT OF A. D. BUCHMUELLER, EXECUTIVE DIRECTOR, CHILD STUDY ASSOCIATION OF AMERICA

Mr. ELLIOTT. Mr. Buchmueller, you are the 23d witness we have today and, if you will, summarize, or proceed in whatever manner you care to within a 10-minute period. We will appreciate it.

Mr. BUCHMUELLER. I will make it very brief, Mr. Chairman.

I just want to mention that I am very pleased that we have the opportunity of talking to the committee today as we have previously on other matters you have been interested in, such as prevention of delinquency.

Mr. ELLIOTT. Mr. Buchmueller represents the Child Study Association of America.

Mr. BUCHMUELLER. As the committee may recall, the Child Study Association of America has the program of working with parents and training professional persons to work with parents to prevent problems of family relationships developing and, in this particular field of working with parents of children with handicaps during the past couple of years, we have been requested by more and more agencies, local and national, as well as private, voluntary, and governmental, to develop programs to work with parents in groups, particularly in this way: that as medicine has advanced its research and treatment programs for the development of services for the handicapped and chronically ill children, there has been an increasing trend to keep youngsters in hospitals and institutions a lesser period of time, and, therefore, place a greater burden on parents and families for their care and training development.

As a result of this, we have been working with a number of institutions, such as the Institutes for Physical Medicine here in New York, and the Children's Medical Center in Boston, in the development of training programs to train such persons as public health nurses, medical social workers, physicians and others, to work with parents in groups in the further understanding of the emotional as well as physical needs of youngsters with chronic illnesses and physical handicaps.

As a result of this, the week before last an institute provided by the Children's Medical Society of Boston and the Child Study Association of America was conducted for professional persons in Boston to explore and develop the needs as well as the resources available to carry on this kind of work—that is, to be of help to parents in groups in understanding and dealing with the problems of everyday living with children with handicaps so that programs of rehabilitation of these youngsters can have a more sound foundation in earlier life.

Since this was an institute that was held just a little more than a week ago, we do not have the proceedings as yet; but, with your permission, I would like to submit to you the summary of the addresses given to the general session, as well as the summaries of the workshops of the several days of institute in order to have this available to you, and see what can be done as far as work with parents when resources are available for the handicapped children.

Mr. ELLIOTT. Without objection, the several summaries referred to by Mr. Buchmueller will be received and made a part of the committee's files.

Mr. Buchmueller, if you could get those things down within a few pages, we could include them in the record as a part of your testimony, if you care to.

Do you think you could have them within 10 days?

Mr. BUCHMUELLER. Yes. These would have to be summaries.

Mr. ELLIOTT. If you really summarize, say, within 10 or 15 pages, we will receive it as part of your testimony, and the committee would have the benefit of it.

If you send us a big, thick book, though, we may not get around to reading it.

Mr. BUCHMUELLER. I appreciate that.

Mr. ELLIOTT. Send it to my office at Jasper, Ala., if you will.

Mr. BUCHMUELLER. The reason we are very happy to be able to present this point of view is that although we realize there are tremendous needs for services to the handicapped and chronically ill, in direct medical as well as social services, we feel that by developing some of these services to work with parents must necessarily form a foundation upon which other kinds of activities can be based for later life.

I would be very happy to answer any questions that any of the gentlemen would like to raise.

Mr. ELLIOTT. Are there any questions of Mr. Buchmueller?

If not, thank you very much, Mr. Buchmueller. We will expect to hear from you again later.

Mr. BUCHMUELLER. Thank you.

Mr. ELLIOTT. For the last time: Are Mr. Loberfeld, Mr. Bluestein, Mr. Cloud, Mr. Scher, or Miss Tuttle present?

Miss Tuttle was actually not scheduled to be here until 4:10 p.m. I have 4:05 now. If Miss Tuttle should come in in the next 5 or 10 minutes, we will accept her statement in writing for the record; or if she wants to return tomorrow morning, she can be heard at that time.

At this point I will place into the record a statement of the American Diabetes Association, dated October 28, 1959, and also a statement

of the Vocational Advisory Service, New York, N.Y., dated October 28, 1959.

(The statements referred to follow:)

STATEMENT BY THE AMERICAN DIABETES ASSOCIATION

The American Diabetes Association was organized and incorporated as a medical organization in 1940. The association is a nonprofit membership organization and the only national organization of its kind serving in the field of diabetes in the United States.

The association's membership today numbers about 2,500 physicians and other scientists and includes members from every State in the Union, from Puerto Rico, and from 27 foreign countries.

The broad objectives of the association, in the language of its constitution and bylaws, are "to further the general welfare through acquisition and dissemination of useful and accurate knowledge and information regarding diabetes mellitus and to undertake in the public interest such activities as will improve the physical welfare of persons having that disorder." To these ends, the association strives—

- (1) To promote among physicians and others the free exchange of knowledge with respect to diabetes mellitus;
- (2) To improve the standards of treatment;
- (3) To promote medical research by individuals, hospitals, clinics, universities, and other institutions;
- (4) To educate the public in the early recognition of the disease and in the importance of medical supervision of its treatment;
- (5) To distribute accurate information to the general public by literature, meetings, and other appropriate means;
- (6) To develop educational methods designed to give diabetic patients a better understanding of their disease;
- (7) To encourage the formation of subsidiary groups which will cooperate actively with the association in its program.

The association now has more than 35 boards and committees which are active in virtually every phase of diabetes. To assist the American Diabetes Association in fulfilling its objectives, 41 local and State affiliate associations have been established throughout the United States. These affiliates carry out the program of the national organization in the fields of professional, patient, and public education at the local level. Active contact is maintained with more than 900 county and State medical societies which have working committees on diabetes, as well as many national, international, and government agencies and organizations. It has been a member of the National Health Council since 1944 and was one of the charter members of the International Diabetes Federation in 1952.

It is estimated that there are more than 2 million diabetics in the United States and almost one-half of that number are unaware that they have the ailment. Approximately 4,750,000 living today are potential diabetics, which means that they will develop the condition sometime during their lives. Almost 65,000 persons become diabetic each year. It is estimated that four out of every five diabetics is in the 40-and-over-age group. The following table represents, generally, the incidence of diabetes by age groups:

Age groups:	Cases of diabetes
up to 20.....	1 in 2,500
20 to 40.....	1 in 1,000
40 to 50.....	1 in 200
50 to 60.....	1 in 100
60 to 70.....	1 in 50

In carrying out its general purposes, the American Diabetes Association conducts a broad program, primarily educational in nature, and directed to the diabetic patient, to the public, and to the members of the medical profession.

Public education and detection

Each year during the third week in November, the American Diabetes Association, with the cooperation of its 41 affiliates and county and State medical societies throughout the country, observe Diabetes Week, the annual highlight of a year-round program in education and detection. During this period an intensive nationwide search is made for unknown diabetics and materials for

millions of tests designed for mass screening are distributed. This is combined with a broad educational program to acquaint all segments of the community with the important facts and symptoms relating to diabetes through appropriate literature and through the media of newspapers, magazines, radio and television. Labor, industry, schools, pharmacists, civic organizations, and other groups participate and a special effort is made to reach elderly diabetics. It is suggested that each community set aside 1 day during Diabetes Week to be known as Senior Citizen's Day and that the local organization responsible for the diabetes program cooperate with Senior Citizens' Clubs, Golden Age Clubs, welfare departments, homes for the aged, churches, and all other groups within the community. This entire program emphasizes the importance of early detection and adequate control of the condition. Active participation of public or voluntary groups is sought to develop a communitywide detection drive, especially during Diabetes Week. As indicated in a survey of State and local projects compiled by the staff of the Committee on Labor and Public Welfare, "Studies of the Aged and Aging," Volume X, January, 1957, many health departments are cooperating in the conducting of diabetes-detection programs.

Pilot studies are conducted from time to time for the purpose of developing and evaluating new mass screening techniques. The most recent of these was held in the fall of 1958 by affiliates of the American Diabetes Association in Atlanta, Mich., St. Louis, and Dallas. This study resulted in the adoption of a new method for processing the urine testing unit known as the Dreyapak.

In addition, the association prepared a public exhibit entitled "What Is Diabetes?" which is made available for showing to the general public. This exhibit, 10 copies of which are available, is in constant circulation at health fairs, county and State fairs and expositions, public buildings, on television, and such miscellaneous events as farm and home week programs.

Patient education

The increase in the number of local lay societies of affiliates has greatly strengthened the association's work in patient education. There can be no substitute for educational work done at first hand in the community and literally scores of meetings are now held each year by our affiliates. These include lectures, teaching classes, panel discussions, "cooking schools," and a variety of social activities which well lend themselves to educational purposes.

The American Diabetes Association also publishes a bimonthly magazine for diabetics and their families which now has a worldwide circulation of more than 55,000 copies. Arrangements have recently been concluded with the National Braille Press to publish copies of "ADA Forecast" in Braille for blind diabetics. The association is cooperating with the American Foundation for the Blind in the preparation of a transcribed "Talking Book" series consisting of transcriptions of 19 outstanding articles from "ADA Forecast." For those diabetics whose complications include blindness, copies of these transcriptions may be borrowed through the 30 regional libraries of the U.S. Library of Congress.

Forty-eight articles of special interest from "ADA Forecast" are now available in leaflet form and 200,000 copies of these articles have already been widely distributed.

The association has also prepared a 32-page booklet entitled "Facts About Diabetes," especially for the newly detected diabetic and his family and the interested general public. Over 71,000 copies have been distributed.

In response to a widely expressed need, the American Diabetes Association has just published "A Cookbook for Diabetics," a 176-page compilation of recipes and menus. Available at very low cost (\$1) this book is considered to be of special value because diet is still the keystone in the treatment of all diabetics, whether they are controlled by diet alone or by diet along with insulin or the newer oral compounds.

The association suggests that all diabetics carry a suitable means of identification and the association publishes diabetes-identification cards which include a place for the diabetic's name, address, and phone number, his physician's name, address, and phone number, type of insulin and dosage.

Professional education

The annual meeting of the American Diabetes Association is both the scientific and organizational center of association activities. The scientific sessions of the annual meetings are a clearinghouse for information collected or developed by individual members or invited guests and offer those in attendance an unusually complete summary of current information. There are now among the associ-

ation's various committees and boards 12 which are devoted to scientific discussion or to the consideration of scientific problems in the field.

The association has conducted seven annual 3-day postgraduate courses for physicians which have maintained a consistently high standard. The faculty has included a number of physicians eminent in the field and the series has been attended not only by physicians but by graduate students, medical students, interns, residents, and fellows. The postgraduate courses include basic information on diabetes and its treatment, as well as information on its recent developments. In this area, too, the association feels that the maximum effectiveness of its educational program can only be achieved through active, local cooperation. Affiliates are conducting clinical meetings regularly and many have their own postgraduate seminars, symposia or regular scientific sessions. In other areas, many county and State medical societies frequently devote all or a part of their scientific sessions to the subject of diabetes.

The journal *Diabetes*, published by the American Diabetes Association, is in its eighth year of publication and is virtually the only scientific journal in the world devoted exclusively to this ailment. Its circulation has increased steadily and now includes more than 3,600 physicians and other scientists particularly interested in this field of medicine. A number of articles and abstracts have appeared in the journal which relate to the problems inherent in the older diabetic and, particularly, with reference to cardiovascular problems. Of the several degenerative complications of diabetes, those of cardiovascular origin are probably the most significant.

The association also publishes a 95-page "Diabetes Guide Book for the Physician," second edition, which is designed to aid the practicing physician in the management of diabetic patients. Recently the guidebook was supplemented with an addendum on tolbutamide, an oral hypoglycemic compound.

A 24-page booklet entitled "Meal Planning With Exchange Lists" was also developed in cooperation with the U.S. Public Health Service and the American Dietetic Association and was prepared for physicians to help diabetics to select foods. This booklet was revised in 1957 and supplemented with a new section for juvenile diabetics. Our association, alone, has distributed about 90,000 of these booklets and approximately 150,000 exchange lists.

The American Diabetes Association has five scientific exhibits, one of which is displayed each year at the convention of the American Medical Association. They are available for and distributed to scientific organizations for display at scientific meetings throughout the country. These exhibits are entitled "Diabetes Detection by the Physician," "Management of Diabetes Mellitus," "Pathology of Diabetes," "Vascular Complications of Diabetes" and "Diabetes—Today and Tomorrow: The Expanding Role of the Doctor."

A thorough discussion and examination of teaching of diabetes in American medical schools was conducted at a joint meeting sponsored by our association in cooperation with the National Institute of Arthritis and Metabolic Diseases on May 3, 1958. Representatives of nearly all medical schools attended and a transcript of discussions on the planning and operation of diabetes teaching programs will soon be available for distribution. A similar session is scheduled to be held in Los Angeles in January of 1960.

Recently the association inaugurated a program under which it will pay the travel expenses of speakers to address the clinical group of affiliate associations. Wherever possible, schedules are arranged so as to enable the speakers to also address lay groups during their visit.

A subcommittee on standardization of the committee on professional education is now preparing diagnostic criteria for diabetes mellitus and, in addition, a glossary of terms relating to the condition and the classification of the varieties of diabetes.

The association's medical student and intern essay contest with prizes for the best paper on diabetes and for the best case report or review article is now going into its seventh year and appears to stimulate a constantly greater interest.

Research

The association's committee on research and fellowships has chosen to use the funds at its disposal, in general, for the support of physicians and other scientists interested in research rather than specific research projects. There is general agreement that the greatest need is to encourage young scientists to develop and to employ their talents in this vitally important field. The association has awarded three research fellowships for the 1959-60 academic year, and renewed a research fellowship for the second year. In addition, the asso-

ciation is administering a grant on the study of the metabolism of sorbitol in the human being.

Further, on the basis of an extensive survey to determine the need for such a service, a plan has been approved for the publication of a semimonthly collection of abstracts of literature on diabetes from every available source throughout the world. Financial assistance for this project is being furnished through the National Institutes of Health and it is expected to result in a prominent and comprehensive coverage of recent developments of importance to research investigators.

Other related activities

The committee on employment of the American Diabetes Association recently completed a survey concerning the employment of diabetics among 127 leading business and industrial concerns throughout the country. An analysis of the survey, as well as a statement of the committee suggesting standards for the employment of diabetics in industry and business was published in the journal "Diabetes." The interest and response aroused have been widespread and a number of firms have requested copies of the report for distribution to subsidiaries. The committee concluded that an enlightened attitude on the employment of diabetics exists to an encouraging extent among these concerns. A brochure combining the results of this survey and the committee's statement on employment will soon be published and prepared for distribution.

The committee on statistics of the association prepares reports on the recent statistics of diabetes which are published at least twice each year in the Journal "Diabetes." The membership of the association and other readers of the journal are thus made promptly aware of detailed figures representing recent trends relating to diabetes.

Affiliates of the American Diabetes Association have been made aware of the importance of developing programs for the instruction of police authorities throughout the country of the problems encountered by diabetics who are temporarily incapacitated as a result of their condition. Through our affiliates and through law-enforcement publications and agencies, it is hoped that police will be acquainted with the several factors which may result in such behavior in order that prompt medical aid will be secured.

The American Diabetes Association believes that it can best serve the well-being of all diabetics, elderly and otherwise, by increasing the effectiveness of this four-point program. Except in dealing with those complications which are recognized to be inherent in the aging diabetic, these individuals can be expected to benefit from the same program that is of benefit to all other diabetics. Committees of the association, including its committee on policies, have under constant consideration new methods for accomplishing this objective, and the association is willing, in this connection, to assume such new responsibilities as may be both practical and constructive. Some illustrations of this interest are the pilot studies, previously referred to, of new mass detection methods; the soon-to-be inaugurated system of diabetes abstracts; the meeting, last year, with the representatives of the Nation's medical schools, on the teaching of diabetes; the publication of "A Cookbook for Diabetics," and the awarding of additional research fellowships. All of these new activities are a reflection of the association's desire to keep pace with the needs of all American diabetics.

Since the average longevity of the American population is increasing, diabetes, which is a degenerative disorder, is more prevalent among the aging and aged. This greater prevalence may be expected to lead to a greater incidence of cardiovascular complications, most often found among the elderly. Because of this the association hopes that increasing attention can be diverted to the detection of diabetes among the elderly, to a continuing study of cardiovascular complications, and to those new research areas that may be developed by such further study. Much attention has been given to cardiovascular complications in the association's journal, "Diabetes," and in the association's annual postgraduate courses and scientific sessions. (See "The Vascular Complications of Diabetes Mellitus, a Clinical Study," by J. W. Bryfogle, M.D., and R. F. Bradley, M.D., "Diabetes," journal of the American Diabetes Association. March-April 1957, VI, No. 2, pp. 159-166, and "Sequelae of Arteriosclerosis of the Aorta and Coronary Arteries, a Statistical Study in Diabetes Mellitus," by Sidney Goldenberg, M.D., Morris Alex, M.D., and Herman Blumenthal, M.D. Ibid. March-April 1958, VII, No. 2, pp. 98-107.) A large number of the abstracts carried in the journal deal with cardiovascular problems (which can lead to such complications as blindness, gangrene, kidney disease, varicose ulcers, cerebral accidents, and

high blood pressure) and a number of the articles appearing in the journal discuss aspects of these disorders. More information is required in the entire field of diabetes, but, perhaps, in no area more than the cardiovascular complications of diabetes mellitus.

Because diabetes is but one part of the overall health problems of the American population, the American Diabetes Association hesitates to suggest relative responsibilities for voluntary groups, local communities, or State and Federal governmental agencies. The association does believe, however, that voluntary groups play an important role in providing leadership and direction for health programs. A number of the members of the association are also most active in the programs conducted by other national health organizations and agencies.

The association, in carrying on its own program, has found that there can be no effective substitute for active local programs in education and detection which are undertaken with the active interest, cooperation, and participation of community organizations and of local medical groups. The American Diabetes Association, in attempting to create and to encourage as many such local programs as possible, and to enhance their effectiveness by a carefully planned overall coordination and cooperation, welcomes the cooperation of any group, community, or governmental agency.

Available publications

As an example of the materials which have been prepared in the development of the association's progress, copies of the following are enclosed:

Patient education:

- "ADA Forecast" (May-June 1959)
- "ADA Forecast," reprint series (complete set)
- "A Cookbook for Diabetics"
- "Facts About Diabetes"
- "Diabetes—Check Facts"

Public education and case finding:

- Organizational kit, Diabetes Detection Drive (1958), including—
 - "Organizing Your Diabetes Detection Drive, a Manual for Chairmen"
 - "Finding the Unknown Diabetic: The Physician's Role"
 - "A Job That Will Pay Off for Business and Industry: Helping To Detect Diabetes"
 - "Detecting Diabetes: What It Means to the Workingman"
 - "A Responsibility for Pharmacists: Helping To Detect Diabetes"
 - "A Program for Women: Helping To Detect Diabetes"
- "The Hunt for Hidden Diabetics," by Patricia and Ron Deutsch, the Saturday Evening Post, December 6, 1958, pages 20-21

Professional education:

- "Diabetes Guide for the Physician" (second edition)
- "Meal Planning With Exchange Lists"
- A copy of the program of the seventh annual postgraduate course
- A copy of the program of the scientific sessions of the 19th annual meeting
- "Recent Statistics in Diabetes" (four articles from the 1957-59 issues of "Diabetes")
- The journal, "Diabetes" (July-August 1959) (March-April 1958) (March-April 1957)

Other publications:

- "Employment of Diabetics," a statement of the committee on employment
- "Analysis of a Survey Concerning Employment of Diabetics in Some Major Industries"

STATEMENT BY THE VOCATIONAL ADVISORY SERVICE, NEW YORK, N.Y.

Vocational Advisory Service has for 40 years been working in the field of educational and vocational counseling; and as a part of our program we have been concerned with the education, training and employment of the handicapped. During these years we have found that while it is not always possible to think in terms of paid employment as we begin to work with the severely handicapped, often the developing of avocational interests serves as a bridge to a possible vocational goal. And even where this goal does not prove attainable, our experience has shown that the severely handicapped can be helped to lead more

satisfying and more independent lives. We are, therefore, very much interested in the work of the Subcommittee on Special Education, and especially in the bill H.R. 3465, independent living.

We should like to bring to your attention two special service-study projects which we are currently conducting, the findings of which we think might be useful to the committee.

First, we are in the sixth year of a 7-year pilot study of vocational counseling for young people with cardiac damage or a history of rheumatic fever, which we are conducting under the sponsorship of the New York and the American Heart Associations. The study, designed for both service and research, has had the cooperation of the New York City Department of Health and the Board of Education.

It has sought to determine the needs of this special group, and the value of early vocational counseling in meeting these needs.

The young people enrolled in this project will be counseled 1 year past their high school graduation or its equivalent, toward medically approved occupations and personally satisfying work lives. (Attached is a copy of the preliminary report, published in December 1956. The final report will be available in the fall of 1960.)

Second, at the request of the Handicapped Children's Home Service—a local agency concerned with the needs of severely handicapped young people, as they return to their homes from hospitals—we have this year initiated a special project in which we will seek to discover whether imaginative vocational counseling can help young people with severe physical handicaps lead more satisfying lives. The study will also consider what are the special problems involved in counseling these young people—as an example, the probable increased stress on avocational interests that may bring to the badly handicapped young person a fuller sense of his own worth, and more satisfactory life adjustment.

Findings of this study are, of course, not yet available.

While work with the handicapped is only a part of our program, this group has always been of deep concern to us, because of our conviction that vocational counseling can play an essential role in their total rehabilitation.

Mr. ELLIOTT. At this time, the committee will recess until 10 a.m., tomorrow, when we will reconvene in this room.

(Whereupon, at 4:05 p.m., the committee recessed, to reconvene at 10 a.m., Thursday, October 29, 1959.)

SPECIAL EDUCATION AND REHABILITATION

THURSDAY, OCTOBER 29, 1959

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON SPECIAL EDUCATION OF THE
COMMITTEE ON EDUCATION AND LABOR,
New York, N.Y.

The subcommittee met at 10 a.m., pursuant to recess, at the 71st Regiment Armory, Park Avenue and 34th Street, New York, N.Y., Hon. Carl Elliott (chairman of the subcommittee) presiding.

Present: Representatives Barden (chairman of the committee), Elliott (chairman of the subcommittee), Daniels, Giaimo, Lafore, and Wainwright.

Staff members present: Mary P. Allen, clerk, Subcommittee on Special Education.

Mr. ELLIOTT. The subcommittee will be in order.

We will proceed to hear the witnesses that are listed for today.

It will be necessary, as we did yesterday, to limit the time of each witness to 10 minutes. We heard 24 or 25 witnesses yesterday, but since we have an additional 10 today, it will be necessary that I enforce the time limitation a little more closely than we did yesterday.

We are happy to have the members of our subcommittee present. On my left is Mr. Wainwright, who represents a New York district.

On his left is Mr. Lafore, of Pennsylvania.

On my right is Mr. Daniels, of New Jersey.

And on his right is Mr. Giaimo, of Connecticut.

Our first witness is Dr. Lauretta Bender, principal research scientist, Department of Mental Hygiene, New York State.

Dr. Bender, will you come forward?

STATEMENT OF LAURETTA BENDER, M.D., PRINCIPAL RESEARCH SCIENTIST, DEPARTMENT OF MENTAL HYGIENE, NEW YORK STATE

Mr. ELLIOTT. Dr. Bender, on my immediate right is the Honorable Graham A. Barden, chairman of the full Committee on Education and Labor, from the State of North Carolina, and on my extreme left is Mr. John Lindsay, who represents the district of New York in which we are now holding this hearing.

You may proceed, Dr. Bender.

Dr. BENDER. Mr. Congressmen, I am an M.D., and a child psychiatrist by specialty. I have been a public servant in this community for more than 25 years.

For the first 20 or more, I was the child psychiatrist at Bellevue City Hospital, where I saw the stream of disturbed children, emo-

tionally disturbed children, that passed through the city into various State institutions or which happened in most instances, back again into the community, sometimes improved and sometimes not.

In the last 3 years, I have had the privilege of being with the New York State Department of Mental Hygiene in the capacity that you mentioned, but also as consultant to the Department of Mental Hygiene in the field of child psychiatry.

That includes not only my concern with all children under 16 who are in State hospitals in the State of New York, which amounts to more than 2,000 at the present time, but also all children who have psychiatric problems who are in the institutions for the mentally retarded.

This amounts to another probably 2,000 who are in the high grade level, and, therefore, salvageable, so to speak, probably salvageable.

I also confer with the Department of Welfare concerning those children who are in the correctional institutions for the boys and girls under the age of 16.

Consequently, I have been able to see the changing attitudes toward the emotionally disturbed, mentally retarded, and so-called socially acting out, or, if they are caught, the so-called delinquent child in the State of New York for the past 25 years and have followed many of them into adulthood.

I have been interested in research, but only in clinical research, not in the White Tower type, which limits one.

I would be glad to make two points today, but I will settle for one in the 10 minutes.

The point I want to make concerns the midadolescent, particularly the boy, since they are the largest number.

I would like to make the point that through all of these different institution, whether it is for the mentally retarded, the delinquent, or in the mental hospitals, we have the same type of boy. We have just as many mentally disturbed in the other two as we do in the hospital, and just as many retarded in the hospital and just as many delinquent in all the places.

It is almost a tossup where a boy goes.

The major problem, as I see it, from a point of view of education, and trying to tie it up with Federal programs, is that these boys' greatest needs are in four areas.

In the first place, they are, by and large, all academically retarded. These boys who fail to make a social adjustment in the community, and who have to have some kind of public institutional care, on actual statistical study, it is shown that from 75 to 85 percent of them are nonreaders.

This doesn't mean they are 2 years retarded. It means they are nonreaders, they cannot read.

These are boys from the age of 12 to 16.

I, myself, as a psychiatrist, am completely convinced that the best therapeutic program, and by therapeutic I mean therapeutic in terms of medical for this group of boys, in order to make them emotionally and mentally more healthy would be to teach them to read and to get adequate reading projects, even as late as in their midadolescence.

There, of course, could be a preventative program, but I am not speaking of that now.

The next thing that these boys need is vocational training. Our hospitals, for instance, have no facilities for vocational training, although we have at the present time 2,000 of these children and they are flowing through very rapidly.

I may, by the way, make a point that is very important. That is that our attitude in mental hospitals has changed very radically in the last 2 years, since we have gotten the drug treatments and the new physiological treatments.

Patients don't go to State hospitals to stay for the rest of their lives, or to get away from their community.

We are aiming in the State of New York to have a hospital in every community and for the individuals to remain community-connected throughout.

The majority of these boys are returned to the community. They need desperately to have vocational guidance and training.

The third area that they need is socializing group experiences with which they can identify in a wholesome way rather than with their gangs, or what you might call supervised recreation for all their spare time.

Then if it could possibly be obtained, and it can only be obtained in a few cases, they need to be individualized, and let's find out what each can contribute to the world in his unique individual capacity.

I know you already have, and this ties in, your vocational rehabilitation program, and the possibility of this vocational rehabilitation program being advanced into the large group of institutionalized boys, in order to help them get rehabilitated—one should hardly use the word rehabilitated, if there is a word rehabilitated for these boys it should be used—is an educational program which would save more in the way of chronic institutional care, of remember citizenship, if you want to call it that, or mulling around of these boys, because if they get out of one institution, they get into another.

My argument here is that I consider the reading lag, for instance, one of the main causes for their maladjustment.

It is true they have many other things, but we can't give homes to every one of these boys. We can teach them to read. We can't give everyone of them a psychoanalysis, which I don't believe they should have anyway, but we can give them vocational training, and we can see to it that they get recreational supervision in the community.

The majority of these boys, regardless of their diagnosis, return to the community, and any kind of followup studies that we make show that most doctors are entirely too pessimistic about the outlook of their patients, and that most boys and girls have a growing capacity which will make it possible for them to reach out and obtain help and to get back into the community.

It is often just a sheer accident that they do get into institutions.

I may make the statement that every one in an institution or anyone who has ever been in an institution or ever will be in an institution, there are at least three equally disturbed, with equal problems, that are still in the community.

I might just go on one point further and that is to say that the older age group, as we go into the institutions, are simply a few years beyond the stage when they did not get this help and could still re-

spond to it if they got it, so that you could carry this on up into adult education just as well.

I would like to make one other point, because it is an area I am much interested in.

That is the lower age level. We have very recently in child psychiatry separated out a large number of young children who are not developing properly, who formerly were considered mentally defective.

We now call them emotionally disturbed. This is dislocated, in my opinion, although I have been largely influential in this situation because of the use of the word schizophrenia—a large number of children whose parents are mulling around about and demanding special services and special care.

These children are not much different from the usual retarded children, and have the same needs.

Their parents are making a special point of this because the schizophrenic child has a potentially schizophrenic parent, and they represent a special problem for that reason.

In this particular area, there are questions which I am not willing to answer as clearly as I did in the other area; namely, what to do about these children in terms of public education.

Offhand, it would be my feeling that they should get hospital care as long as they need it, and then when they are able to get into a group of children, even if it is with the retarded or whatever other group of children it is, they should then be put in that group, that they should not be isolated and segregated by diagnosis.

I think segregation by diagnosis is as malicious as almost everything else, because a clinical diagnosis does not indicate how a child is behaving. It represents a whole global concept of laboratory tests and things of that sort.

It doesn't give you a picture of the child.

It is my feeling that these children should be diagnosed and evaluated and when they can return to a class which is already set up for other types of children, even if it is retarded, they might be able to get into that particular group.

Mr. ELLIOTT. Are there any questions of this witness?

Mr. WAINWRIGHT. I would like to ask one.

Dr. Bender, do you feel there is any disadvantage of locating geographically, we will say, in one concentrated area, mental hospitals, State, local, and Federal schools for mentally retarded children?

By that I am saying if you took a geographical area of some 20 miles and you concentrated these institutions in that locality, do you think that that is good, bad, or indifferent?

Dr. BENDER. I think it is very bad. I think your hospital facilities should belong to the community, and it should be distributed.

We should just get used to the idea that children that go to mental hospitals or for the mentally defective should not be isolated from the community.

In Creekmore, where we serve Queens County and Kings County, they go home weekends. They are discharged, even if they have to come back again.

We work with the parents in that unit and with the agencies in the unit.

I think it will take a tremendous stigma away from this, and also get us away from the idea that patients go away in the State somewhere and are lost to the homes and communities in which they live.

Mr. WAINWRIGHT. In a concentrated area on Long Island there are some 50,000 people of this kind belonging to the various branches of the government. I was interested in your reaction.

Dr. BENDER. As a matter of fact, Long Island is a big island. It is almost a State, itself.

Mr. WAINWRIGHT. I am talking about just in terms of that particular area of Long Island.

Dr. BENDER. I think by and large those hospitals are all serving the whole State.

Mr. WAINWRIGHT. The whole State?

Dr. BENDER. Yes, but we are changing it very rapidly, and it has been changed within the past months. It is much worse, the children that go out of the city of New York, and go up to Rockland, in Rockland County, those children get lost.

They never get back. When they get back, they have no school to go to, no home to go to.

Mr. WAINWRIGHT. I was not thinking just in terms of children. I was speaking of all patients.

Dr. BENDER. Yes, but it is true of adults. As I said before, we are discharging patients were rapidly. To rehabilitate them, you have to have them near at home.

It is far better that the hospitals do their own aftercare. Those doctors know the patients.

Mr. WAINWRIGHT. Thank you.

Mr. ELLIOTT. Thank you.

Our next witness is Mrs. Nash, executive director of the Jewish Society for the Deaf.

STATEMENT OF MRS. TANYA NASH, EXECUTIVE DIRECTOR, JEWISH SOCIETY FOR THE DEAF

Mr. ELLIOTT. Mrs. Nash, you may proceed with the limitation which you heard me speak of before time.

Mrs. NASH. I represent the Jewish Society for the Deaf. We are a nonsectarian agency which is supported totally by federation of Jewish philanthropists of New York.

We are the only professionally organized agency for the deaf in the United States.

There are parent groups, clubs, and other such lay groups, but we are the only agency established for professional case work with the profoundly deaf.

I want to make it clear at the very beginning that the profoundly deaf are unfortunately lost in the whole problem of the overly impaired. These are not people who are like the hard of hearing, except that they are more hard of hearing.

These are entirely different kinds of people with different kinds of communication problems and social problems.

We would like to recommend that in considering special legislation for those with impaired hearing, that the profoundly deaf, at birth or during infancy, numbering approximately 200,000, be con-

sidered separately from the hard of hearing who number in the millions.

It is precisely because the profoundly deaf are such a small segment of the hearing impaired population that they have been bypassed, when from the very beginning they should have been recognized as a group with unique and more difficult problems than those whose impairment had been less severe.

The profoundly deaf have no usable hearing within the speech range, and the most that can be attained for them with the use of hearing aids is to amplify sounds in their environment.

The hard of hearing, however, have functional hearing, and the use of the hearing aid thus increases the usefulness of this residual hearing.

The goal for the hard of hearing is integration with the normal hearing, and that has usually been attained with good successes.

However, this is not a realistic social goal for those with profound hearing loss, for ultimately they do not articulate clearly enough to be understood by the general population.

Thus, the profoundly deaf, whenever possible, tend to move to larger cities where they seek out companionship and marriage with those who are similarly afflicted.

Their vocational training problems are also different because they cannot, like the hard of hearing, compete successfully on jobs where intercommunication is required.

From our 30 years with approximately 7,000 profoundly deaf adults on a nonsectarian basis, the rehabilitation evaluations and procedures, as well as the goals now used for the hard of hearing, have not proven realistic, for use with the profoundly deaf.

While all of us hope that research can one day point the way to alleviating the effects of severe hearing and speech handicaps, this can only come about if research is considered separately for the profoundly deaf in all areas, including teaching methods, vocational training, psychological evaluation, and the social services.

Thank you.

Mr. ELLIOTT. Thank you.

Are there any questions of Mrs. Nash?

If not, thank you very much, Mrs. Nash.

Our next witness is Mrs. Felix duPont, Jr., who I understand will be accompanied by Mr. Morris Clapper. They come to us from the National Association for Mental Health.

STATEMENT OF MRS. FELIX DUPONT, JR., NATIONAL ASSOCIATION FOR MENTAL HEALTH; ACCOMPANIED BY MORRIS CLAPPER, NEW YORK, N.Y.

Mrs. DUPONT. Thank you.

Mr. ELLIOTT. Mrs. duPont, you may proceed.

If you care to summarize your statement, you may do that and place the full statement into the record, in the complete record of our proceedings.

You and Mr. Clapper may present your statement together. Since there are two of you, I will allot you 15 minutes instead of 10.

Mrs. DUPONT. Thank you very much, Mr. Chairman.

I represent the National Association for Mental Health, and I presently am acting as the second vice president of that organization.

I will read this through quickly and briefly, because it puts our ideas on the table; and then if you have any questions, Mr. Clapper and I will be very happy to answer them.

The National Association for Mental Health—and its 800 affiliates which are located in 43 States and the District of Columbia, and its more than a million enrolled members and volunteers, heartily endorse House bill 3465, and we urge its speedy enactment.

We have a particular interest in this area, because all of the mental health associations are beginning to be more actively concerned with the whole rehabilitation problem. This is due, of course, to the marked acceleration in the discharge of mental patients, which has confronted the Nation with a new and most acute problem.

In 1955, the State and county mental hospitals, which account for about 85 percent of the Nation's hospitalized mentally ill, discharged 119,150 patients. In 1958, the last year, it has climbed to over 155,000.

The point about this discharge figure, which is most hopeful and encouraging, but which also has its serious and more sad side, is that very often the patients who are discharged are unable to make a good readjustment, and will break down and return to the hospital. The whole problem of care has to be undertaken again.

Of the 71,500 patients who were readmitted to the State and county hospitals in 1958, there were people who were on discharge from the hospitals who returned to an intolerable situation at home, the situation where they might even meet with outward rejection and unsuitable living arrangements, and even unsuitable occupational arrangements. Among these, also, were patients who were psychologically unable to cope even with conditions which might have, for the completely healthy person, been considered optimum but which for them were detrimental and hazardous.

A meaningful and comprehensive program of rehabilitation must take into account the thousands of former patients now living in communities throughout the country who, because of such handicaps, will eventually break down entirely and be compelled to rush to the hospital.

At present, the rehabilitation program of the Federal Government is concerned primarily with vocational training and job placement, and through this program tens of thousands of Americans have been helped to find their rightful places in jobs and in their communities.

But a program which concerns itself only with vocational rehabilitation leaves out of consideration a larger area of handicap. There are hundreds of thousands of Americans who are psychologically and physically incapacitated, not only to the point where they cannot work but also to the point where they are unable now to live reasonably satisfying and productive lives.

It is quite clear that people suffering from continuing psychological or physical handicaps will be hampered in their vocational rehabilitation and will be unqualified for and unable to take advantage of the services offered through the Office of Vocational Rehabilitation. It stands to reason that any services which will relieve such

persons of their psychological handicap will improve their potential rehabilitation.

The independent living rehabilitation services provided in House bill 3465 will provide the much needed counseling, psychological, and related services to deal with continuing psychological handicaps. The benefits of these services will, without question, help to restore a large number of wage earners.

The National Association for Mental Health also is interested in this bill, because we believe that the rehabilitation of the ex-patient, socially and psychologically, is as important as his vocational rehabilitation, and that that really is an end in itself.

In certain cases they may not necessarily have to be employed, but they must be socially and emotionally adjusted to be able to take their place again in the community and as a member of their family, so that the service is very much needed.

We wanted to point out to you that the 1946 national Mental Health Act provided the impetus for the enactment of statewide community mental health acts, and 10 States have now these community mental health acts.

You all know that under those acts the State and the municipality share the responsibility for the development of support of rehabilitation—medical and social and vocational. The Federal Government has demonstrated its tremendous job in giving this impetus in this area, and we feel that in the rehabilitation the same impetus will be given from the bill.

Therefore, we urge its passage.

If there are any questions, I will be very glad to answer them.

Mr. ELLIOTT. Are there any questions of Mrs. duPont?

Mr. LAFORE. My question may not be relevant to your testimony, but, as a point of personal interest, have the discharges balanced with the admissions?

Mrs. DUPONT. Mr. Clapper will answer that.

Mr. CLAPPER. The discharges have not balanced with the readmissions which, I think, is an important figure, and very appropriate to your figure. We have seen for the first time in 1958 a stabilization of the bed population of mental hospitals; that is, there has not been any increase. We reached a plateau. However, the readmissions have increased 9.5 percent over the previous year.

This points to this fact that the climate for receiving a discharged person in the community is not such as to retain him there for the desirable period of time. We feel, therefore, that the services Mrs. duPont described, which are proposed in H.R. 3565, would substantially remedy this readmission rate.

Mr. LAFORE. There is a possibility that in some instances they have been discharged too soon, is there?

Mr. CLAPPER. I don't think that has been measured or gaged, officially, but I think the provision of community services might even offset any mistake in early discharge.

Mr. LAFORE. Thank you.

Mr. DANIELS. You stated there are 10 States which adopted community mental health acts. Do you know the names of those States, or can you furnish them?

Mr. CLAPPER. Minnesota is one; New York; California is one of the early ones; and New Jersey.

Mr. DANIELS. May I suggest, if it meets with the approval of the rest of the committee, that you submit the names of those States to us.

Mr. CLAPPER. We will be very happy to do that.

Chairman BARDEN. May I ask this question: Just what did you mean when you said the climate was not good for readmission.

Mr. CLAPPER. I meant the climate in the community was not sufficiently adequate to retain those discharged patients in the community.

I will be specific about that. There are inadequate housing facilities. Many patients discharged from hospitals have no home to return to, and there is the problem of finding adequate housing. This area has been pioneered by the Veterans' Administration over the past 10 years or so in developing a very expansive foster home problem.

There is a serious gap in the provisions for the discharged patient, mental patient. The provision of recreation or social activities, which would help the discharged patient to reenter the community, are almost unavailable, except in certain sporadic cases. The provision of adequate vocational rehabilitation programs which will accept a mental patient are very difficult to find.

I recently conducted a study of 86 rehabilitation centers throughout this country, the leading ones, and found that 25 rehabilitation centers admit some ex-mental patients. This is a small part of meeting the tremendous needs.

Furthermore, until now, rehabilitation legislation had to insist on a vocational feasibility for the acceptance of a patient into that program.

So we had to be absolutely sure that a person was definite job-potential before he could be included in a program.

That meant setting a specific time goal for being prepared for that job.

These are some of the aspects of the unfavorable climate for the readjustments of the discharged patients.

Mr. ELLIOTT. The gentleman from New York, Mr. Lindsay.

Mr. LINDSAY. Mrs. duPont, does your organization concern itself with brain injured persons also?

Mrs. duPONT. It concerns itself with all of the mentally ill. The brain injured is really more in an area which is a little bit separate.

Mr. LINDSAY. There was a witness yesterday who testified that the bill would have to be amended in order to include brain injured persons.

Mr. CLAPPER. I would doubt that very much from my reading of the bill. We are equally concerned, as a mental health association, with the mental problems of people generally and the emotional problems of people with physical handicaps as well.

As I read the bills, both H.R. 3465 and S. 772, I see no reason for requiring any special inclusion.

Mr. LINDSAY. Is your organization a fund-raising organization.

Mr. CLAPPER. Yes, it is.

Mr. LINDSAY. How much money do you raise a year?

Mr. CLAPPER. Our 800 affiliate organizations in 45 States raised about \$6 million in 1959.

In addition, nationally, we do receive special grants from foundations and corporations in the interest of our research program, which has newly begun, about 2 years ago, which we hope will increase.

Chairman BARDEN. May I ask this:

Is there a charge for the services in the institutions that you promote?

Mr. CLAPPER. No, sir. We have no fees for any of our services.

Mrs. duPONT. I think we might clarify that a little bit for you, if I may, Mr. Barden. We don't run any direct services, the National Association for Mental Hygiene, except in very isolated cases.

There are two or three child guidance clinics that have been run and started by us, but we don't care for or give treatment to any of the mentally ill people.

We are concerned with educating the public to see that they get the proper care from the proper institution, more than we are with direct services.

Chairman BARDEN. Remembering some of the trouble I got into in trying to pass the Barden-La Follette Act, are the organizations interested in projects such as yours and the development of a program pretty well together or are you fussing among each other.

Mrs. duPONT. I think we are pretty well together. I think there are separate groups working. The mentally retarded has their own organization, and the emotionally disturbed children.

But I have not found at all any conflict of interest. In every one of these cases we seem to be working together.

Chairman BARDEN. Just a hint as to what the results will be, we could not get to first base on the blind section of the Barden-La Follette bill until all the organizations got together. They did get together and worked together wonderfully well, and Congress passed the act.

It did not cover everything to be covered for the next 40 years, but it was a good act to start with and everybody agreed with it.

I wanted to just drop the hint that Congress has enough troubles that naturally fall in its way, and sometimes there is an inclination to go around the fight instead of trying to go into it.

Mr. ELLIOTT. Thank you very much. Your testimony will be very helpful. We appreciate it very much.

(The formal statement of Mrs. duPont follows:)

TESTIMONY BY NAMH IN BEHALF OF H.R. 3465, THE REHABILITATION ACT OF 1959

The National Association for Mental Health, and its 800 affiliates which are located in 43 States and the District of Columbia, and its more than a million enrolled members and volunteers, heartily endorse House bill 3465 and we urge its speedy enactment.

Rehabilitation of the recovered mental patient—the process of helping him to find a warm welcome, a home, proper followup medical care, and employment have always been a major concern of the National Association for Mental Health.

In the past several years, however, this concern has taken on urgency and importance. A marked acceleration in the discharge of mental patients has confronted the Nation with a new and acute problem. In 1955, the State and county mental hospitals (which house about 85 percent of the Nation's hospitalized mentally ill) discharged 119,150 patients. In 1956 this figure rose to 133,200 and continued to climb, reaching 155,000 in 1958.

It is a well-known fact—and mental hospital administrators throughout the country will testify most energetically to this—that patients who are unable to make a good readjustment, very often break down once more and have to return to the hospital. Many of the 71,500 patients who were readmitted to the

State and county mental hospitals in 1958 were people who, on their discharge from the hospital, were returned to an intolerable situation—a situation in which they were met with outright rejection, or were unable to find suitable living arrangements, or adequate followup medical care, or a suitable occupational situation. Among these, also were patients who were psychologically and physically unable to cope even with conditions, which might have, for the completely healthy person, been considered to be optimum—but which were for the not yet fully recovered person detrimental and hazardous.

A meaningful and comprehensive program of rehabilitation must take into account the thousands of former mental patients, now living in communities throughout the country—who because of such handicaps will eventually break down entirely and be compelled to return to the hospital—or at the best make a poor readjustment, and become a burden to themselves, their families, and their communities.

At the present, the rehabilitation program of the Federal Government is concerned primarily with vocational training and job placement of those suffering from physical or mental handicap as a result of previous illness, or ongoing disability. Through this program tens of thousands of Americans have been helped to find their rightful places on their jobs and in their communities. But a program which concerns itself only with vocational rehabilitation, leaves out of consideration a large area of handicap. There are hundreds of thousands of Americans who are psychologically and physically incapacitated not only to the point where they cannot work, but also to the point where they are unable now to live reasonably satisfying and productive lives.

It is quite clear that people suffering from continuing psychological or physical handicap will be hampered in their vocational rehabilitation, and will be unqualified for and unable to take advantage of the services offered through the Office of Vocational Rehabilitation and its counterparts. It stands to reason that any services which will relieve such persons of their psychological or physical handicap will improve their potential for vocational rehabilitation and help restore them to the ranks of those who are self-supporting and who no longer need public assistance because of handicap. The independent living rehabilitation services provided in House bill 3465 will provide counseling, psychological and related services to deal with continuing psychological handicap, as well as physical restoration and related services to deal with continuing physical handicap. The benefits of these services will, without question, help to restore thousands of Americans to the ranks of wage earners.

But this is only one reason why the National Association for Mental Health so strongly endorses this entire piece of legislation and particularly its section providing for independent living rehabilitation services.

While gainful employment of a handicapped person is an eminently important goal, both for the individual and for society, we cannot hold with the thesis that vocational rehabilitation must be the *sine qua non* of any rehabilitation program, and that we shall not concern ourselves with social, psychological, and medical rehabilitation unless these contribute to vocational rehabilitation. We believe that personal and social adjustment are ultimate goals in themselves—whether or not they contribute to a person's vocational rehabilitation, and we feel that this principle is recognized and served in the independent living provisions of H.R. 3465. We therefore strongly endorse this provision, and the entire legislative proposal in which it is embodied.

Those who have studied the growth of community services for the treatment and prevention of mental illness and for the rehabilitation of the mentally ill, will have noted that the enactment of Federal legislation in 1946—the National Mental Health Act—provided the impetus for enactment of statewide community mental health acts in some 10 States to date—acts under which the State and its municipalities undertake the responsibility for the development of State and municipal support throughout the country for programs of social, medical, and vocational rehabilitation. The Federal Government will thus once more have demonstrated its unique role in initiating desperately needed services for large sections of the population, with the awareness that the impetus so provided would stimulate adoption of responsibility for these services by the State and municipal governments.

Mr. ELLIOTT. Our next witness is Dr. John Eisenson, director of the speech center at Queens College.

STATEMENT OF DR. JON EISENSEN, DIRECTOR, SPEECH CENTER,
QUEENS COLLEGE

Mr. EISENSEN. Thank you.

Mr. ELLIOTT. Dr. Eisen, where is your Queens College located?

Mr. EISENSEN. Queens College is in the borough of Queens, Flushing, N.Y.

Mr. ELLIOTT. Mr. Eisen, I necessarily have to limit you to about 10 minutes. You may proceed.

Mr. EISENSEN. Thank you, sir.

Let me state briefly that I feel privileged to appear before the subcommittee and to offer the testimony, and that I am doing so in a joint capacity as a representative of the New York State Psychological Association and as a director of the Queens College Speech and Hearing Clinic.

I have prepared a statement which I would like to read.

Our growing and aging population has created an urgent need for rehabilitative specialists in the field of speech and hearing. The most conservative estimates indicate that by 1960 the incidence of persons with seriously impaired speech or hearing will approximate 9 million.

Specifically, the estimate for those with significant speech impairments, and by significant, I mean impairments that will compel attention and that will interfere with training, education, adjustment, vocational accomplishment, the incidence for those with speech is 6,164,427, and for those with hearing impairment, the estimated figure is 2,773,844.

During the past 25 years, the professional speech pathologist and audiologists have undertaken the work of rehabilitation of adults and children with speech defects and hearing defects.

Colleges and universities have provided training for personnel.

The allied professions of speech pathology and audiology have developed so that today academic training is available in many of our leading universities.

Unfortunately, our training institutions cannot provide a sufficient number of trained personnel to meet the compelling needs of those with excommunicative disorders.

The Office of Vocational Rehabilitation estimates that there is need at minimum of 1 audiologist and pathologist for 50,000 population to take care of those children and adults whose needs exceed the treatment provided in schools.

By 1960, this will mean that 7,366 speech audiologists and pathologists will be needed for persons of impaired speech and hearing who are not of school age or whose difficulties are more severe as to require more specialized attention than the schools can provide.

Twenty-five thousand speech and hearing specialists will be needed in schools alone.

As of now, we have but a small fraction of the required number of specialists.

The American Speech and Hearing Association estimates 2,000 certified and 5,000 uncertified specialists.

It may be unrealistic to hope that within a period of 2 to 5 years we can attract and train 32,000 specialists in the fields of speech and hearing.

We, however, set realistic sights for increasing our training goals so that your urgent needs can be met in 10 years if not 2, 3, or 4 years from now.

I should like to recommend the following toward this end:

The expansion of present training programs in colleges and universities.

For the immediate present, the training of trainers should be emphasized.

For the most part, this would mean masters and doctoral programs in speech and hearing with courses to include related areas of physical, emotional and mental handicaps.

Second, the expansion of physical facilities for the treatment of persons with impaired speech or hearing at hospitals, colleges, and university clinics and other agencies to serve the dual function of providing a place for training personnel as well for assisting those who themselves are in need of help.

Third, an increase in the total number of grants and in the sizes of the stipends for those students in graduate training programs who continue the training at the masters and doctors level.

Stipend should reflect number of dependents as well as years of training.

We are losing personnel because graduate students cannot afford to stay in their programs, especially after they are married and have children.

The establishment of subsidized internships and residences in approved training centers.

Such a program might parallel the one for the training of psychologists that is now widespread throughout the country.

In many communities, and perhaps in many States, the cost of such programs may be prohibitive. At least it is in the innumerable stages.

House Joint Resolution 316 recognizes the urgent need for a sharper increase in the number of speech pathologists and audiologists.

The New York State Psychological Association is grateful for the opportunities your committee has provided to permit me to appear to offer this brief testimony. As the director of a college speech and hearing clinic with a waiting list that almost always exceeds a regular caseload of approximately 200, I am personally grateful for your committee's interest in the needs of children and adults who are in need of speech and hearing rehabilitation.

Mr. ELLIOTT. Thank you very much, Doctor.

Are there any questions of Dr. Eisenson?

If not, thank you very much. Your testimony will be very helpful and we appreciate it, Doctor.

Our next witness is Dr. David Kahn, director, psychological services and research, New York State Psychological Association.

STATEMENT OF DR. DAVID KAHN, DIRECTOR, PSYCHOLOGICAL SERVICES AND RESEARCH, NEW YORK STATE PSYCHOLOGICAL ASSOCIATION; ACCOMPANIED BY PAUL ROTTER, M.D., ASSISTANT TO THE SUPERINTENDENT, LEXINGTON SCHOOL, NEW YORK, N.Y.

Mr. KAHN. I am representing the New York State Psychological Association, sir. I happen to be director of the psychological services of the Lexington School for the Deaf.

I am not representing the Lexington School for the Deaf.

Mr. ELLIOTT. For the purpose of the record, will the gentleman accompanying you give his name?

Dr. ROTTER. I am Dr. Paul Rotter, assistant to the superintendent at the Lexington School, and was asked to appear by the New York State Psychological Association.

Mr. ELLIOTT. You gentlemen may proceed.

Mr. KAHN. I should like to speak first to H.J. Res. 494, introduced by Mr. Elliott, and state that this resolution in general is supported wholeheartedly by the New York State Psychological Association.

My emphasis following deals with the important specific psychological areas which might be considered and incorporated into the final bill.

I speak to title I, training teachers for the deaf, section 101.

In a statement concerning how grants-in-aid should be used by the institution involved, it might be well to include some provisions for the continued research aimed at evaluating and thus improving the programs for the training of teachers for the deaf.

There is some evidence to support the fact that the preparation of teachers of the deaf should include more courses dealing with such areas as child development, personality theory, abnormal psychology, guidance, and other psychologically oriented courses.

A recent study conducted by Dr. Paul Rotter, which followed up approximately 70 trained teachers of the deaf, revealed that a large portion of this group received very little training in the above areas, either in undergraduate work or graduate work.

As of the present, very few schools for the deaf employ psychological or psychiatric personnel on their staff.

It is probable that it will be some time before the smaller of these schools make use of these services.

It would indeed be helpful if, in both theses smaller schools and in the larger ones which do employ psychologists, the teachers were aware of the psychological ramifications of the communication problems and the effects of these on family relationships.

The same resolution, section 105, it would be of great benefit, I feel, if the advisory committee on the training of teachers for the deaf were to include at least one psychologist who was well experienced in such areas as learning theory, perception, psychophysical methods, research and the psychology of the physically handicapped.

Section 106, the suggested appropriation of \$1.5 million for the years 1959 and 1960, appear to be somewhat inadequate for the total program of training sufficient teachers for the deaf.

Along with maintaining scholarships, for which the cost is increasing, there is research needed to constantly evaluate these programs, there is a need for increased personnel for training and administrative purposes, and a need for more adequate facilities and equipment to be utilized in these training programs.

House Resolutions 316, since House Resolution 494 introduced by Mr. Elliott supersedes resolution 316, and incorporated and adds to it, the earlier dated resolution, we should like to recommend that House Resolution 494 be considered as a replacement for House Resolution 316.

I have one statement concerning H.R. 3465. In general, this House bill is supported by the New York State Psychological Association. It is suggested, however, that section 203, page 16, section B, be amended to read as follows:

That all medical and related health services are prescribed by or under the formal supervision of personnel licensed to practice medicine or surgery in the State—

and I add—

that all psychological and related services are prescribed by or under the formal supervision of persons deemed competent to practice psychology—

and so forth—

in the State.

Thank you

Mr. ELLIOTT. Thank you very much.

Dr. Rotter, do you have any statement?

Dr. ROTTER. No. We put that in together.

Mr. ELLIOTT. Thank you so much.

Our next witness is Dr. Margaret E. Condon, counselor with physically handicapped students, the City College.

STATEMENT OF MRS. MARGARET E. CONDON, COUNSELOR WITH PHYSICALLY HANDICAPPED STUDENTS, THE CITY COLLEGE, NEW YORK, N.Y.

Mrs. CONDON. At City College of New York, which is like Queens College, Brooklyn, Hunter College, in that they are nonpaying, non-resident colleges in this city, we have had programs for physically handicapped students for many years.

City College, I believe, was the first. It was established in 1946. At the present time, I am working with about 150 physically handicapped students, chiefly blind, deaf, hard-of-hearing, postpolio, epileptics, diabetis, and post-TB's.

These students are ambulatory. We have had to refuse many wheelchair cases at the City College because of our physical facilities.

We are an old college, about 110 years of age. We do not have many buildings with ramps and modern facilities. Some of our old buildings would be impossible for a person in a wheelchair to navigate.

So the wheelchair cases are referred to Hunter College.

In the last few years, we have been receiving a number of requests to send someone into this home to educate on the college level.

As a result of these many requests, the division of vocational rehabilitation on the homebound asked me to join with the community council of Greater New York last year to be on a subcommittee for meeting the needs of the homebound on the college level.

As a result of that year's work, we found that in the 168 colleges in the New York State area, there is nothing similar to the University of Illinois for a paraplegic or a double-crutched polio, who is non-ambulatory.

We wondered, after investigating the program at Foster University for the homebound, which is done by tutoring, telephone, TV, and the person seen maybe twice a year for examinations, interviews, that this is quite an expensive kind of education.

After looking into the work being done in Ohio State and the University of Illinois, we wondered if it would not be more practical in the area of New York to have a university similar to the University of Illinois for homebound college persons. We felt that we are losing a great many people with good minds if they are just allowed to sit home.

If we send somebody in to the home to test these people, send someone to tutor them, to educate them by telephone, by TV, that becomes a very expensive proposition. In fact, it amounts to about \$10,000 to \$15,000 per person. Whereas, if we had in this area a university similar to the University of Illinois, the person would be meeting with people of his own age group.

There is one boy now from Hastings, N.Y., at the University of Illinois, who said, "It is so good to talk with someone who isn't 20 or 30 years older than I am."

If we send somebody into the home to educate them, again they are isolated and alone. If we had a university in this area, they would be meeting with people of their own age level, learning how to live with this age level. To me, this is one of our greatest needs in the area of New York.

Are there any questions?

Mr. WAINWRIGHT. I would like to ask a question if I may.

Mr. ELLIOTT. The gentleman from New York, Mr. Wainwright.

Mr. WAINWRIGHT. Is not your suggestion, primarily, the type of institution you are suggesting, a State problem, as the State of Illinois University is entirely operated by them?

Mrs. CONDON. The Federal Government, I am sure, gives a great deal to the University of Illinois. There are many \$250,000 research programs connected with this kind of center.

Mr. WAINWRIGHT. But you are suggesting a university as such, or an institution, as such, to do the type of work you are describing. That would have to be started by the State, would it not, and then Federal aid would go to the State?

But originally would have to start with the State?

Mrs. CONDON. Then what is the best way to get this type of thing?

Mr. WAINWRIGHT. I do not know. I am asking the question.

Mrs. CONDON. We really don't know. The community council of New York worked on this all last year. We had Miss Gambel come down from Boston to see if this might be the most practical way to attack this problem.

We found this a very expensive way to do it. That might be better in a place like Stonyrock, N.Y., or any area, particularly a university connected with a medical center. These people then could have physiotherapy and the various therapies, if needed. We are just looking for information. If you feel that we should pressure the State, we will pressure the State.

If we should pressure the Federal Government—we are only anxious that a university of this kind be started, because there are too many people just doing nothing, with good brains.

Mr. WAINWRIGHT. Thank you.

Mr. ELLIOTT. Thank you very much, Dr. Condon.

Our next witness is Mr. Cyril Wilcock, consultant, New York State Department of Education, Department for the Gifted.

STATEMENT OF CYRIL WILCOCK, CONSULTANT, NEW YORK STATE DEPARTMENT OF EDUCATION, DEPARTMENT FOR THE GIFTED

Mr. WILCOCK. I appreciate this opportunity to talk to you this morning, and tell you a little bit concerning my views.

Mr. ELLIOTT. We are happy to have you, Mr. Wilcock. Let me say that as much as I regret it, could you give us your statement in about 10 minutes?

Mr. WILCOCK. Yes, I can do that.

This outline is simply to facilitate the report that I am going to make. There will be a second report on the gifted, made by Mrs. Madeline Coutant, this afternoon. She will emphasize the specific recommendations of our group.

My statement has to do with giving you a little bit of an understanding of where we are in the State and with regard to the gifted and some of the unmet needs. She will be more specific about them later.

As I indicate in the outline, we are doing a good deal here in the State to meet the needs of the gifted and talented youngsters. We have in our own State education departments a special program for meeting needs in science, technology, and the education of the talented. In fact, we have a bulletin which has been published, which gives us a guide in this area.

We also have had a great deal of interest and effort by the New York State Teachers Association the American Association for the Gifted Children, as well as increased local effort.

Without a doubt, as we review information in this field, we know that this State is one of the leader States in the matter of educating gifted children. We have some very specific programs that have been enacted by our own legislature in the last 2 years to help and advance this cause.

Under item 2, I indicate that the legislature has made a grant of \$200,000 available each of the last 2 years to encourage research and experimental practice in the field of the gifted. We have had over 175 requests for that kind of money, with enough money to finance about 25 of them.

Here is an area that is crying for need.

Also, our own State education department, through the legislature, has been increasing regent scholarships for these talented and gifted students.

I have indicated the growth in my outline of the expected goal that the legislature is working toward in some year in the not too distant future. There will be about 10 percent of these regent scholarships available for about 143,000 seniors graduated each year.

We have in this State some very unique programs that have been developed out in the rural areas. They become pretty well known, and established patterns for gifted youngsters. Some of those mentioned are Monroe County, Lewis County, Herkimer County, the Catskill area project and the Oneida area project.

As you know, in this State we have more schools for gifted and talented youngsters than any other State. They are mostly to be found in New York City.

Mr. ELLIOTT. How do you define a gifted youngster, Mr. Wilcock?

Mr. WILCOCK. Well, an intellectually gifted youngster is usually someone accepted at 125 or higher on an individually administered certified examination.

On a talented youngster, we tend to take the definition of Dr. Wyte, that anyone who performs in some talent area, like social leadership, arts, speech, about the 85th percentile of his own group naturally probably ought to be looked at and probably is gifted.

We don't have a better rule than this in the talents area because we haven't much research in this area. But these two guides help us a good deal.

Chairman BARDEN. Are you beginning the appraisal in the high school or in the college?

Mr. WILCOCK. We are beginning in the elementary. We believe that earlier identification of these youngsters is necessary and more should be done in the elementary schools.

Some of the publications that I will leave with you for your examination, if you want them, spell out some of the things in our State bulletins that are being done in the elementary schools, where there is considerable movement in behalf of these youngsters.

Most of it has been secondary, at higher education, but now we have a movement at the elementary level, believing that the later you wait the sorrier the results or the less the results will be, and especially in the areas of talents.

Apparently we have to get started much earlier in talents than we heretofore have been doing.

Chairman BARDEN. From a practical angle, say the high school student qualifies as in the top group to which you referred. Then that student goes to college.

Mr. WILCOCK. That is right.

Chairman BARDEN. How long must he be an outstanding student?

Mr. WILCOCK. Well, he should be an outstanding student each year, or he is very likely to be lopped off by the college, because he is probably under some scholarship aid, if not full scholarship.

Chairman BARDEN. Pursuing that further, suppose he is in such financial situation that he must help himself in college?

Mr. WILCOCK. Most colleges have some aid program, either through work programs or scholarship aids.

Chairman BARDEN. But very few of them, if any—certainly none that I have been associated with—have any fund where they could pay the total amount.

Mr. WILCOCK. That is right.

Chairman BARDEN. Would that boy or girl be expected to take outside work to support himself or herself to the extent necessary and still remain in the top bracket?

Mr. WILCOCK. Yes; if he has any scholarship aid at all, he would be expected to. Otherwise, he would forfeit what he is getting.

Chairman BARDEN. Are you not expecting a lot from him?

Mr. WILCOCK. I think it is a lot, but you asked me what is the situation. I think this is generally it.

Chairman BARDEN. From a practical angle, undoubtedly that boy or girl could remain in the top bracket with nothing to do but study. But from a practical angle, he or she has to spend a good part of the time when not in classes in providing the funds to stay in school.

Would you not wind up with more able men or more able women, and better rounded out men and women, even though they did not remain in the top bracket?

Mr. WILCOCK. Well, if you are asking me, I think it depends. It depends on the individual. I don't think you can generalize a thing of this kind.

I have seen some where some work experience has been very good for them, and I have seen others where it has not been.

Chairman BARDEN. Have you ever seen anybody that it hurt to work?

Mr. WILCOCK. No; I haven't, not generally speaking.

Pushing on, because I have a limited amount of time, we have, even though we are doing a great deal in the State, some unmet needs. I try to indicate those very briefly at the bottom of the first page.

We have a need to find teachers and increase and train teachers in this field.

We are short in teachers in general, but we need more for the gifted.

We need more research in this area.

Here is where maybe some Federal money could help, because it is costly to do it, the kind of research that we need in this area. We have an unmet need of supplying additional special personnel for this kind of work.

We do need the help of a psychologist and a guidance person, and so on, when dealing with people of those great gifts.

I have listed them in my outline.

I want to conclude by saying that we think we are making a good effort in New York State in behalf of these youngsters, but there are many unmet needs. The biggest problem we have to face is to find the money to accomplish what we feel we need in terms of some of these unmet needs.

As I said at the beginning, Mrs. Countant will appear later, and she will give you the specific recommendations of our workshop on the gifted.

Thank you very kindly.

Do you wish any of these pamphlets?

Mr. ELLIOTT. The gentleman from New York has a question.

Mr. WAINWRIGHT. This committee, every member who is here, worked on the National Defense Education Act. Title 5 of the National Defense Education Act specifically deals with the problem you are discussing today, the training of better guidance counselors, also training funds for the training of counselors, to determine who the gifted child may be. The philosophy that you have expressed here today was the philosophy that many of us hoped would be in the bill completely, but it was worded out.

Mr. WILCOCK. We appreciate titles 3 and 5, I want to tell you, very, very much.

We hope something more can be done.

Mr. GIAIMO. Are you asking for specific legislation and appropriation for gifted children, or are you arguing in general in favor of a general Federal support bill, such as we now have pending?

Mr. WILCOCK. We are not talking against other children. We are talking for gifted children.

What we are saying is we don't care if the grants are general or specific, but certainly there should be some provision for upgrading the instruction of gifted children.

Mr. GIAIMO. What you are saying, in effect, is that you do need Federal assistance to provide such proper supervisors and trained personnel to take care of these problems.

Mr. WILCOCK. We need some help in this direction; yes, sir.

Mr. DANIELS. Who would set up the program, sir?

Mr. WILCOCK. I think those should be left to the local communities and State education departments.

Mr. DANIELS. Not the Federal Government?

Mr. WILCOCK. No, I am sure not. I believe in the grassroots approach.

Mr. ELLIOTT. Thank you very much.

Mr. WILCOCK. Thank you.

(The formal statement of Mr. Wilcock follows:)

(Formal statement of Cyril Wilcock, consultant, New York State Department of Education, Department for the Gifted)

"THERE IS NOTHING SO UNEQUAL AS THE EQUAL TREATMENT OF UNEQUALS."—
REPORT ON THE EDUCATION OF INTELLECTUALLY GIFTED AND TALENTED CHILDREN
AND YOUTH IN NEW YORK STATE

INTRODUCTORY STATEMENT ABOUT THE PRESENT SITUATION IN NEW YORK STATE

1. Interest in the intellectually gifted and talented in the schools of New York State is very high at the moment and is likely to continue so for many years to come.

This is so because of—

(a) National concern about our perilous position in science at the moment.

(b) The National Defense Education Act which help better educate human resources.

(c) The New York Regents program for meeting needs in science, technology, and education of the talented.

(d) The interest and investment in effort of the New York State Teachers Association and the American Association for Gifted Children.

(e) Increased local interest and effort.

2. Without doubt, New York State is in advance of other States in providing for its gifted children and youth at the present time.

This is indicated by the fact that—

(a) The State education department in this State established the first position for the gifted, that of coordinator of education for the gifted,

3 years ago. During the last school-year, the coordinator helped establish or further develop gifted programs in 94 schools.

(b) The New York Legislature of 1958 and 1959 made available a grant of money amounting to \$200,000 for each of these years to encourage and help finance promising experimental programs for gifted and talented students in school. Over 175 applications were received with money enough for but 25 approved projects.

(c) The New York Legislature recently increased the number of Regent scholarships from 7,385 in 1958 to 7,669 for 1959 amounting to \$10 million. (The Regents hope to someday offer scholarships for 10 percent of the approximately 143,000 seniors each year.)

(d) The New York State Education Department has also developed helpful publications on the subject of the gifted designed to educate teacher and the public as to the need to do more for the gifted and talented.

(e) Local efforts in the State have been abundant and often outstanding, resulting in unique and promising program patterns, of national interest and acclaim, such as those in Monroe County, Lewis County, Herkimer County, the Catskill area, the Oneida area.

3. All cities in the State have some provision for its gifted and talented in school, whether partial programs or rather full ones. Also, there are more special schools for the gifted and talented in this State than in any other.

4. One may conclude on the subject of the present provision for the gifted and talented in New York State that a great deal is now being done, more than in any other State, but there still remains much more to be accomplished, with money being the chief requirement for further advance in this important area of education.

UNMET NEEDS

1. New York State still has many unmet needs in the area of the education of the intellectually gifted and talented as follows:

(a) The need to increase and train teachers.

(b) The need to do more research.

(c) The need to recruit and supply additional special personnel services.

(d) The need to upgrade curriculum.

(e) The need to provide specialized books and other materials.

(f) The need to offer special "refresher" institutes to teachers of the gifted.

2. An indication of the unfinished nature of the task of educating intellectually gifted and talented students in New York State can be gathered from the following facts:

(a) At present, approximately 58 percent of the elementary schools in the State have some provision for these students.

(b) At present, about 71 percent of the junior high schools of the State make some provision for these students.

(c) At the moment, about 90 percent of the senior high schools of the State have some kind of program for these students.

(d) At present, the demand for help from schools and other educational organizations in the State, of the State education department and the office of the coordinator of education for the gifted, average about six letters a day and this load has about doubled each of the past 3 years.

CONCLUDING STATEMENT

1. The State of New York is now making a rather maximum effort in behalf of its intellectually gifted and talented students in school. There is a real and urgent need for additional financial help to permit the State of New York to completely develop a school program for these students. Costs for gifted programs in this State tend to amount to one-half again as much as spent for regular instruction. Mrs. Madeline Coutant, chairman of the committee for the gifted, of the Workshop, will later spell out the specific recommendations of our committee for your consideration and action.

Thank you very much.

Mr. ELLIOTT. It has just been called to my attention that we have visitors here in the hearing room from the New York Institute for Education of the Blind.

May I say to that class of students that we are happy to have you visit these hearings.

Our next witness is Mr. Lee C. Dowling, director, Joint Legislative Committee on Mental Retardation.

Is Mr. Dowling here?

If not, our next witness is Mr. Joseph Weingold, executive director, Association for the Help of Retarded Children.

If he is not here, is Dr. J. Morrison Brady, medical director, Muscular Dystrophy Association of America here?

If Dr. Brady is not here, the next witness is Dr. Harry Sands, director of program of the United Epilepsy Association.

**STATEMENT OF HARRY SANDS, M.D., DIRECTOR OF PROGRAM,
UNITED EPILEPSY ASSOCIATION**

Mr. ELLIOTT. Dr. Sands, we are happy to have you.

Because of the large number of witnesses, we have agreed that we must limit each witness to 10 minutes. If you can summarize your statement to 10 minutes, we would appreciate it.

Dr. SANDS. I think they can do it in 5.

I am Dr. Harry Sands, program director of the United Epilepsy Association.

I address myself to the field of neurology.

In neurological disorders, it is estimated it claims 20 million Americans. Epilepsy holds a very central position in neurology, with an incidence of 1.5 million persons.

Eighty percent of the cases of epilepsy have their onset during early childhood and adolescence.

I would like to limit my remarks to, one, the need at the moment as we see it in neurology in general, and epilepsy in particular, and then to extend my remarks to what can possibly be done about some of these needs.

At the moment, there are about 20 training units in neurology in the 179 medical schools in our country. There are less than 400 trained neurologists in the country at large to deal with the 20 million persons with neurological disorders, and this rather small group of trained neurologists has to deal with the vast problem of teaching, research, and manning the clinics, and, of course, patient care.

County after county in our Nation is devoid of any neurologists at all, so that general practitioners have no consultants to go to, so must do the best they can with the knowledge they have.

Epilepsy in particular, despite the availability of anticonvulsive drugs, the last of which was introduced in 1928, only 20 percent of the epileptic population are on adequate medical treatment, many of them still receiving their medication from mail-order drug houses.

Partly this reflects the long time that it takes to get knowledge from our laboratories to bedside care.

Partly this is reflected in the statements just made, namely, the few training facilities for neurologists in medical schools, and, in addition, these small number of neurologists in the country at large.

Mr. ELLIOTT. Dr. Sands, I heard last year that the National Institutes of Health were about to announce some very fine method of treatment, or perhaps it was a drug, for epilepsy, but I never did hear whether or not the announcement of that discovery had been made. Do you know, Dr. Sands?

Dr. SANDS. Yes, I do. I think you are referring to slutamenes and sparogenes that were being developed at the National Institutes of Health.

All of those in convulsive disorders had tremendous hope for this drug. We had hoped that it would break the barrier to our understanding brain metabolism.

Unfortunately, at this point our hope has not worked out. I think in research we must continue digging and digging for new hopes, those that will be stable and those that will sustain themselves.

The Institute is continuing the approach. Though this drug has not worked out, I think the magnificent thing about the studies is that the negative results are leading us to other areas of investigation.

At the moment, though, we still do not have a cure for the million and a half persons with epilepsy.

Mr. ELLIOTT. Thank you.

Chairman BARDEN. May I pursue that a moment?

Is the Federal Government now contributing to the research work that you referred to?

Dr. SANDS. Yes. The research work that I just referred to has been supported very liberally by the Institutes of Neurological Disorders and Blindness, both in their own program and in universities and medical centers throughout the country.

This, of course, has its impact on a community level where persons with epilepsy, both the child and the adult, are forced to live on the edge of impossibility, if you will, in that they are kept out of schools in many communities due to lack of knowledge on the part of the teachers, and administrators and the community at large.

Also, on the adult level, it means that we have a vast pool of our labor force that have convulsions that are kept out of employment when they make it known that they have epilepsy or a history of epilepsy is uncovered.

This, in general, is the problem. I am sure I am not telling you anything that you don't already know.

What can we do about the crucial needs? It seems to me that we must step up the training of neurologists, or else much of the research that we are supporting may remain in the archives of neurology and may go to naught, unless someone is there to apply this newly gained knowledge and to apply that as rapidly as we assemble it.

Another need which stems from this preamble is the development of regional clinics to disseminate the newest knowledge and to disseminate to our physicians, and to put these regional clinics in the position where they disseminate this knowledge through better patient care, so that there would be a shorter gap between discovery and patient care.

It just takes too long between the time that we have the knowledge and the time that it gets down to good treatment.

I should think that the establishment of these regional clinics would do just that.

Then the introduction and extension of mobile diagnosis and consultant clinics to assist the practitioners in the rural clinics.

Again it is the way of disseminating our knowledge to patient care.

Certainly these physicians that operate in rural areas away from the large medical centers need some kind of diagnosis and consultative help until we have adequate neurologists to be present in all counties.

Mobile units would certainly help enormously. The complexity of neurological knowledge, the complexity of all knowledge in our current society, requires a specialist to be present in governmental agencies, such as the Division of Vocational Rehabilitation, in school units, in all the service units that are trying to help the disabled. These specialists would help not only through consultation directly in the services being offered by the agency, but would keep them abreast with the new and modern knowledge.

Again, it is the shortening of the gap between the acquisition of knowledge and good patient care.

It seems to me on the research level we need to augment what we are doing so very well now, augment through the establishment and extension of the notion of supporting men, careers, careers in research.

In addition, supporting laboratories, not just specific studies, but laboratories that are very much like our libraries, repositories for equipment, repositories for technicians, so that when investigators who are working within these universities have notions, they need not apply for a grant to some voluntary or Government agency, but it would be very much like getting a book, to go down and test some of their hypotheses, while they are still enthusiastic about it.

Of course, many of these notions will not pan out. We see that in research all the time.

But for the one or two notions that can be pursued this way, without filling out long forms, whether it be from a voluntary health agency or from a public granting agency, I think this would reward itself enormously.

Then in the area of employment, some agency ought to review the health standards used in employment, both on the civil service levels. Federal, State, and local, and on the industrial level.

How realistic are our health standards when they come to employment, on any level?

It seems there if we could review these health standards in terms of our current knowledge, we might open up a tremendous number of opportunities for our disabled people.

The last recommendation I would make is an increased public information program about our new knowledge. It seems all of us on clinical teams are so patient orienters that that we feel rather guilty if we take time off to do anything else, but look at a patient.

But so many of the stumbling blocks exist by a wall out in the community, a wall which consists of misinformation, a wall which consists of old, antiquated ideas.

In epilepsy, we are still operating under medieval ideas. I think the best people to carry out the public relations programs are the very technicians who know the problem not abstractly, but in terms of feeling, in terms of suffering.

These people ought to be supported and allowed to be articulate to a community and bring their knowledge up to date.

This knowledge ought to be in archives in neurology, ought not to be the private property of doctors. It ought to be everybody's property.

In this way, I think we would shorten the task of meeting the complex problem in neurology, and perhaps this has application to all our problems.

Thank you very much.

Mr. ELLIOTT. Thank you, Dr. Sands.

The next witness is Dr. Joseph Weingold, executive director, Association for the Help of Retarded Children.

STATEMENT OF JOSEPH WEINGOLD, EXECUTIVE DIRECTOR, ASSOCIATION FOR THE HELP OF RETARDED CHILDREN

Mr. ELLIOTT. We are happy to hear you, Mr. Weingold, and request that you limit your presentation to 10 minutes.

Mr. WEINGOLD. Thank you.

I am speaking today as a representative of the New York State Association for the Help of Retarded Children, which is one of the State affiliates of the National Association for Retarded Children.

I am not speaking as a representative, a direct representative of the national association, who either did or will appear for themselves.

Our own association consists of 32 chapters, growing to that size from about seven members in the last 10 years, representing about 90 percent of the population of New York State, and speaking on behalf, I should say, of most of the mentally retarded and their parents in this State.

We operate and support a complex network of services, mostly with funds that come from the general public.

These services include preschool classes, classes for children who do not qualify for public school classes under existing law, recreation, camping, vocational rehabilitation, sheltered workshops, parent counseling, and education, public education, and so forth.

In the year 1957, for example, our association spent over \$1 million on these services in New York State. In addition to this, we operate five sheltered workshops, four of which have received grants from the State by way of section 3 funds under Public Law 565; and in New York City one sheltered workshop which is a research project under a 5-year grant from the Office of Vocational Rehabilitation, now in its fifth and final year.

This grant has been used as the prototype for all similar grants for sheltered workshops for the mentally retarded throughout the country, supported by OVR funds.

In addition to these, we are also the recipient of a grant from the Office of Vocational Rehabilitation for workshops in training of professional personnel in the field of vocational rehabilitation.

I have conducted three such workshops with Professor Abramson in the last three summers.

Although there are over 300 classes which we operate, and other educational services, which makes us keenly aware of the needs in the other fields—teaching training, and so forth, space—I want to limit myself to the vocational rehabilitation aspects of this study.

I am sure that I need not go into the value of the work that has already been done by the Federal Government through the Office of Vocational Rehabilitation in State governments. We all know that from 531 mentally retarded persons rehabilitated in 1955, in 1957

there were 1,094 rehabilitated; and in 1959, it is estimated that 1,750 will be rehabilitated.

The earnings similarly are dramatic as compared with what these people earned before rehabilitation.

But when we consider that period—for example, when 1,700 mentally retarded persons were rehabilitated vocationally through Federal-State programs, there were 80,720 in the total rehabilitation who achieved rehabilitation—we can see how small a portion this large group is in this success story, and how much more has to be done.

I have several suggestions with regard to these matters. One that concerns us very, very much is what is going to happen to these programs now supported by OVR, and/or State grants under section 3.

These are section 4 and section 3 grants under Public Law 565.

Millions of dollars have been and will be spent on setting up such services. The public, through the voluntary agencies of the States, matches the one-third to two-thirds, and in the case of section 3 funds it is one-fourth to three-fourths.

After 2 years, 3 years, 4 years, or 5 years, the theory is that the public will take up the slack, and that we will have sold this to the general public and they will continue.

Regrettably, I must say that this is proving unrealistic. The nature of this handicap is such that most of these workshops must continue to operate at considerable financial deficiencies.

Somewhere along the line, the voluntary agency who is willing to do as much as possible must be helped for a continuing operation if we are not to lose most of the effect of the millions of dollars that have already been spent.

Whether this is a Federal function or a State function is open to considerable debate. It may be that the Federal Government might set up some scheme whereby funds would be siphoned into the States for continuing operation; or, on the other hand, as was brought out in our study group—and I don't want to repeat that now as I am sure it will be said—some method of stimulating and pushing the States into undertaking this task and duty might be devised.

It might be a reallocation or refocusing of section 2 funds. Instead of purchasing individual services, as is now the case, they might make lump-sum payments to voluntary agencies who would contract to service up to a certain number of handicapped during the year.

There is a lot of precedent for that. For example, in New York State, through the youth board, the welfare services and others. In any case, it seems to us that unless something is devised to help the voluntary agencies, not entirely, but on some grant-in-aid basis, to continue the operation of these workshops, these services may be curtailed and in many instances may even have to stop.

Is this worth while financially? That is always important.

In as highly a specialized workshop as ours in New York City, which is research oriented and, therefore, more expensive than it would be for a straight service operation, that costs us a little less \$1,000 per retardate per year.

The costs of institutionalization in New York State is \$1,800 a year solely for care, without any funds for capital construction, retirement, obsolescence of buildings, and so forth.

So there is a net saving of \$800 per year somewhere, to some taxpayers, over a period of maybe 20, 30, or 40 years, because the life expectancy of the mentally retarded today is very near that of the normal person.

That is the first proposal.

The second proposal I would like to make is in regard to section 3 funds under Public Law 565, now known as extension and improvement.

We have received four such grants in New York State. If we got more of them, we could operate and we, as an agency, would be able to stand the difference, financially, at least four more sheltered workshops in this State and perhaps more.

But we are told on the State level that there are no more funds available.

We suggest, therefore, that some thought be given to increasing the funds made available to the States, or a reallocation, rather, than on a population basis—reallocation of these funds under section 3 rather than on a population basis as now exists, so that those areas who are ready to move will receive the aid to do so.

This may be New York State, or California, or Nebraska.

It so happens that I know we are ready. Others may be just as ready, and yet haven't got the funds.

That is the second suggestion I have to make with regard to vocational rehabilitation.

The third point that I want to take up in the few minutes left to me is the independent living bill, which you, Mr. Elliott, have introduced in Congress, in the House of Representatives.

I think that this is probably the second great advance in the field of rehabilitation of the handicapped.

The first, of course, was Public Law 565, and its predecessors. It is the logical step to take if we are going to think of rehabilitating or servicing those who are more handicapped.

It goes without saying that there are hundreds of thousands of handicapped individuals for whom there is no realistic vocational rehabilitation goal who could be helped so materially that it would result in substantial savings to taxpayers. Those are the people who might go into institutions, people who need attendants. Certainly a large number, a significant number are the mentally retarded.

This came home very strongly to us in our association because, as chairman of the national association's vocational rehabilitation committee, I got these letters from all over the country: "What do we do with the youngster who cannot function in a sheltered workshop?" and so forth.

I think this bill is aimed at it, and I think it is a wonderful thing. But on very careful study of the bill, I find, and I may be wrong, that the implementation of the philosophy is contained in "Title 3—Workshops and Rehabilitation Facilities."

All the rest of it is administration, how the funds are going to be used, and so forth, and I submit that the services that are contemplated to achieve the aims of independent living will not—I stress, will not—do this for the mentally retarded.

The language of the bill, speaking of workshops and rehabilitation facilities, follows very closely the wording of Public Law 565 in

the same regard, and if that is so, why didn't we then extend the definition of feasibility under Public Law 565 and get all these people under that law without the need for an independent bill?

Of course, I don't think Public Law 565 can, or was, designed to deal with this type of handicapped person. I feel very strongly we need this new type of legislation.

But our experience has shown that we must think in terms of a new concept of rehabilitation service for this type of severely handicapped individual.

Such a service is more in the nature of a social development center or, if you will, a habitation center for the mentally retarded that will help such individuals to care for themselves as much as possible, utilizing their innate capacities and meaningful use of their day to the end that they will require a minimum or no help from members of their family and may not have to be institutionalized.

Mr. ELLIOTT. Mr. Weingold, I will have to call time on you. Your statement will be made a part of the record at this point.

Mr. WEINGOLD. Thank you, sir.

(The statement referred to follows:)

STATEMENT BY JOSEPH T. WEINGOLD, EXECUTIVE DIRECTOR, NEW YORK STATE ASSOCIATION FOR THE HELP OF RETARDED CHILDREN, INC.

Mr. Chairman and gentlemen, it is a great honor and privilege to have been invited to testify before this distinguished committee on the most urgent needs, national and local, as we see them, in the fields of special education and rehabilitation.

Since there are many who will have testified before this committee on the subject of special education, I should like to limit my remarks to the field of rehabilitation and some observations on the "independent living bill," H.R. 3465, introduced by Mr. Elliott.

The Association for the Help of Retarded Children is a membership corporation consisting of parents and friends of the mentally retarded. Started with 7 parents in 1948, we have grown to 32 chapters representing more than 90 percent of the population of New York State and with more than 10,000 paid family memberships. During this time the association through its chapters has established, is operating and supporting a network of services in New York State, mostly through public giving, including preschool training for the mentally retarded, classes for those not eligible for existing public-school classes, recreation programs, camping, vocational rehabilitation, sheltered workshops, placement and counseling, information services to the parents and parent education, and public education. In 1957, the association through its chapters spent almost \$1 million on such services.

In New York State we operate five sheltered workshops, four of which have received grants from the State by way of section 3 funds under Public Law 565, the Vocational Rehabilitation Act. In New York City, the New York City chapter operates a research project in the vocational rehabilitation of the mentally retarded through a sheltered workshop operation with a grant from the Office of Vocational Rehabilitation which is now in its fifth and final year. In addition, we have also received grants from the Office of Vocational Rehabilitation in the training of professional personnel in the vocational rehabilitation of the mentally retarded and for the past 3 summers I have conducted such workshops in cooperation with Teachers College and Prof. Abraham Jacobs during the summer.

Although our 100 classes or more that we operate in the State makes us keenly aware of the need for teachers, space, curriculum development, and the many other matters that I am sure you have heard about in the field of special education, our specialized experience in the field of vocational rehabilitation qualifies us, perhaps, more to speak in that area. May I say that we have had the most cordial relationships with the Office of Vocational Rehabilitation on a national and local level and the State and local divisions of vocational rehabilitation. The aid that we have received from them, in money and counseling, has been of

invaluable help in developing what we consider to be one of the most dramatic programs in vocational rehabilitation of the handicapped that we have seen in this country. Our experience, however, has made us keenly aware of what might still be done.

I am sure that no one will question today the value of the work that has been done in the field of vocational rehabilitation and the great place that the Office of Vocational Rehabilitation and Federal legislation has had in this development. In the year 1955, for example, 531 persons were rehabilitated vocationally through the Federal-State program. They earned \$24,000 before rehabilitation and \$825,900 after rehabilitation. Coming down to 1957, 1,094 were rehabilitated who earned \$1,851,600 after rehabilitation as against \$44,700 before; 1959, it is estimated that 1,750 mentally retarded persons will have been rehabilitated. A similar dramatic progress can be shown for those who were rehabilitated who had a psychosis, the emotionally disturbed, etc. When, however, we compare these figures with the total number of all handicapped rehabilitated, 57,981 in 1955 and 80,720 in 1958, we can see how small a number the mentally retarded are. We must, therefore, seek ways to bring these services, even more meaningfully, to more of this terribly handicapped and large group.

One of the things that concerns us very much is what will happen to these many facilities and sheltered workshops that are being financed by the Federal Government after such grants cease. We know that the theory is that the community will take up this slack, but we find that these workshops are operating, because of the intense nature of the handicap, at various degrees of financial deficiency.

We should, therefore, be thinking of ways to continue these projects and services, and even expand them, beyond the time when the Federal grants cease under the law as it now exists. Millions of dollars have been spent and many more will be spent on starting such projects, financing research, and nursing them along for a period of time. It seems to us that if they were to be dropped, if services were to fall off or even cease, after Federal grants have ceased, we well may be accused of having spent money in vain. Of course, if not another thing is ever done by the Federal Government, I think that a great work has already been accomplished. It is not in our nature as Americans to rest on our laurels. Hence this inquiry and the searching in which we join.

We should like to propose, therefore, that some thought should be given to make available funds to voluntary organizations and the States or to voluntary organizations through the States, for the continuing operation of workshops and rehabilitation facilities for the mentally retarded who have met desirable standards. I submit that in one way or another government, either on a Federal, State, or local level, pays for these people whether it be through vocational rehabilitation or final institutionalization in view of the lack of such rehabilitation services. On a dollar-and-cents basis it has been demonstrated over and over again that it is cheaper to provide a vocational rehabilitation service and sheltered workshop for a handicapped person than to institutionalize him. The comparative costs are quite astounding. For example, in New York State it costs \$1,800 a year to maintain a mentally retarded person in a State institution. This cost does not include capital construction, retirement of employees, reserve for depreciation, etc. This is a cost solely for maintenance and some other services. As against this, in a highly specialized service such as the sheltered workshop of the New York City chapter of the AHRC, which is research oriented, the cost is a little less than \$1,000 per client. This results in a net saving of \$800 per year (and the life expectancy of the mentally retarded is very near the normal today). In addition to which, the mentally retarded who obtain employment through such service become taxpayers and even those in the sheltered workshop are earners instead of total consumers.

Another proposal that goes along with this is that more Federal funds be made available under the extension and improvement section of Public Law 565 when States surveys show the need for more sheltered workshops or rehabilitation facilities for the mentally retarded. This was very fully discussed, as were many other matters, by my section on mental retardation in the study group in preparation for this committee hearing. I will not press this any further because the statement with regard to the matters we have discussed will be made by someone else and include some of the things I have said here as well as others.

I do feel it important, however, to have stressed what I did concerning the continuing operation of sheltered workshops. I should like also to address myself to something of extreme importance to us in the field of mental retardation, the "independent living" bill.

I think that the concept of this bill is the second great advance in the field of rehabilitation of the handicapped. The first, of course, was the Public Law 565 and its predecessors. Here at last we are coming to grips with the whole question of the severely handicapped for whom vocational goals are not possible to obtain and unrealistic to set. This bill, if enacted, and properly implemented, will result in keeping in the community on an independent level many, many thousands who otherwise would be institutionalized or require special expensive attention usually borne by the State. There is no doubt in my mind, as well, that this measure and its implementation may result in bringing back into the community many of the mentally retarded who previously were considered terminal institutional cases; especially if residential facilities for them in the community are supplied. Again the costs of these community facilities as compared to institutional placement and care are much less.

I should like to point out, however, that although the findings of fact and the declaration of this bill are extremely broad, have enormous philosophical implications, the portion of the bill which seeks to implement this philosophy will not, in its present form, accomplish the purpose. The portion of the bill which treats with the services other than evaluation, etc., is "Title III—Workshops and Rehabilitation Facilities." What seems to be contemplated as the services which will accomplish the purposes of the act is the establishment of workshops and rehabilitation facilities. Language of the act in speaking of workshops and rehabilitation facilities follows very closely the wording of Public Law 565, which is the Vocational Rehabilitation Act. I respectfully submit that for the mentally retarded the establishment of a sheltered workshop or a rehabilitation facility as defined in this act will not accomplish the purpose, nor would this act be necessary if that is the only type of service that will be offered. It seems to us that the Vocational Rehabilitation Act can supply the services that seem to be contemplated in H.R. 3465 if we broaden our philosophy concerning feasibility of the handicapped.

Of course, I don't think that Public Law 565 can or was designed or should deal with this type of handicapped person. I feel very strongly that new type of legislation is necessary and that the purposes of the independent living bill are quite wonderful. Our experience has shown, however, that we must think in terms of a new concept of a rehabilitation service for this type of severely handicapped individual. Such a service is more in the nature of a social development center, or, if you will, a habilitation center, that will help such individuals to care for themselves as much as possible, to utilize their innate capacities to their limit and to be brought together for social and occupational activities and meaningful use of their day to the end that they will require a minimum or no help from other members of the family in daily living and will be able, if institutionalized, to return to the community or if in the community remain there since they will be a minimum burden on society. This is the minimum goal for the mentally retarded. An extension of this goal might be meaningful or even some remunerative work, but this depends on the capacity of the individual and how he will develop. It must not be made as an initial goal and, therefore, I respectfully submit that the concept that a sheltered workshop or rehabilitation facility as is now in the proposed bill will not answer the purposes of the bill and the philosophy it intends to implement.

We have been keenly aware of this problem and especially myself, because of my relationship with the Office of Vocational Rehabilitation through the research grant for our workshop in New York City and my correspondence with the many workshops throughout the country. In addition, for some time I was the chairman of the vocational rehabilitation committee and sheltered employment committees of the National Association for Retarded Children. Everywhere, wherever there were sheltered workshops set up, the question was asked, What are we going to do about these individuals who cannot adjust to a sheltered workshop, function too low, perhaps, and will never achieve a vocational objective? In answer to this and because of the many needs as expressed to us through applications of parents and their children, this association began such a service which we call an Occupational Day Center on East Fifth Street, in space that was contributed to us by an organization in Manhattan. We are at this time, I am happy to say, the recipient of a 3-year mental-health-project grant from the National Institute of Mental Health for the development of this project and to demonstrate its usefulness for the rest of the country. It is a project such as this that must be provided for in any act that seeks to rehabilitate or, as I said before, habilitate the mentally retarded who were included in

the more severely handicapped. I am attaching a copy of the original proposal as made to the National Institute of Mental Health as exhibit A for this committee. You will note that this is intended for a population who (1) is unable to participate in the social life of the workshop, apart from work; (2) is functioning at intellectual levels so low that they cannot appreciate the activities of the workshop; (3) do not join in any meaningful groups; and (4) for whom only special kinds of work, if any, are suitable. These are the youngsters who are presently considered unfeasible for vocational rehabilitation and are presently potential institutionalized retardates in view of the lack of community facilities available. For them, I must repeat, the sheltered workshop and the rehabilitation facility is not the answer. The answer lies, we believe, in a different type of service as exemplified by what we are doing under the grant from the National Institute of Mental Health.

In closing I should like once more to compliment and congratulate this committee on the wonderful work that it is doing. I had the privilege of attending the workshop on mental retardation as a participant in preparation for this hearing and was amazed at the breadth and depth of the considerations there brought forth and the conclusions drawn. I am sure that much, much good will come of this inquiry and stand ready to cooperate in every way possible whenever called upon.

EXHIBIT A

PROPOSED PLAN AND SUPPORTING DATA FOR OCCUPATION DAY CENTER FOR MENTALLY RETARDED YOUNG ADULTS

A. SPECIFIC AIMS

1. *The problem*

Since the resurgence of interest in the mentally retarded, beginning in 1949, there has been a great effort to improve services for the mentally retarded, in and out of institutions, with special emphasis on the development of community facilities. Sparked by the enormous growth of parents groups, more and more classes are being organized for the so-called "educable" child, generally with IQ's over 50; there is a growing concern for the retarded of lower intelligence, generally with IQ's under 50 labeled "trainable" for educational purposes; the 1954 amendment to the Vocational Rehabilitation Act (Public Law 565) enabled many of the parents groups to start vocational rehabilitation and sheltered workshop programs for the retarded adults. But, although such services are part of a "cradle to the grave" program, the emphasis until now has been on the school age child and on those adults (not yet in depth) who are feasible for a vocational training program. It has become evident to us, through our programs for the adults in New York City, Long Island, Westchester, Utica, Watertown, and in many of our other 32 chapters in New York State, that these are adults for whom these programs are not the answer.

This significant group is identified as those not now eligible for the type of activity for which sheltered workshops are designed. This group has certain characteristics identified by us in our various workshops, and in the more than 70 such workshops established throughout the country. These retarded—

(1) Are unable to participate in the social life of the workshop, apart from work;

(2) Are functioning at intellectual levels so low that they cannot appreciate the activities of the shop;

(3) Do not join in any meaningful groups;

(4) For whom only special kinds of work are suitable;

(5) Who tend to be in the group who measure under 40 IQ (although some may be above).

During the year 1957-58, the AHRC in New York City alone received more than 7,000 requests for services. Almost 20 percent of these were for postschool age retarded, 17 and over. These have been the most difficult to help in terms of meaningful programs to help the parents, if they so desire, keep them in the community. Dr. Gerhart Saenger, in "The Adjustment of the Severely Retarded in the Community," a study of former pupils of low IQ classes in New York City from 1929 to 1956, points out that parents tend to think more and more of institutionalization as the child grows older. Thirteen percent were considering institutionalization in the 17 to 20 age group. This goes up to 15 percent in the 21 to 25 age group and 21 percent in the 26 to 30 age group. In almost every instance the answer to the question "Why?" is "There is nothing for him to do in the community and I can't take it."

This lag in services for the adults described becomes more and more evident as services for the school age and evidently vocational feasible adult retarded are developed, since many children in such services, who otherwise might have been institutionalized at an early age, now remain at home and grow to adulthood in the community. For example, although almost 50 percent of the reported school age retarded with IQ's under 50 in New York State are in institutions, of the 124 children in the classes operated by the AHRC (1957-58) only 9 were institutionalized.

If the trend is toward keeping the retarded at home and we are building community services to accomplish this, a most significant group will be deprived of the opportunity to achieve whatever they can and be left by the wayside unless a program is devised to help them realize their potentials to become as independent citizens as possible in their own homes, at least. As a community agency, we feel it is the height of cruelty to advise parents to keep a youngster at home, help the family "adjust," without a direct service to the child.

2. *Aims of the proposed work*

(a) To establish a day center in the community for late teenage and young mentally retarded adults who are (1) presently considered unfeasible for vocational rehabilitation, (2) presently considered to be functioning at a level too low for participation in any existing community program for mentally retarded adults, (3) presently residing at home and devoid of any service related to training or rehabilitation, (4) presently considered potential institutionalized retardates in view of the lack of community facilities available.

(b) To help the retarded remain in the community by providing a socially acceptable way for them to spend their days. Society, and parents, perhaps, do not accept the adult who stays at home all day watching television. The socially acceptable behavior for adults is to leave home in the morning to engage in an acceptable activity and return in the evening. This is minimum and basic.

(c) To train the retarded in the skills of daily living, such as traveling alone, homemaking, good grooming, constructive use of leisure time, etc., in brief to bring him to the point of requiring a minimum or no help from other members of his family in daily living.

(d) To ascertain the extent of growth possible as a result of such training.

(e) To determine the significance of such training to the ability of the individual to function better in the community or, if he is institutionalized, in an institution.

(f) To help the parents to develop greater positive attitudes toward the retarded adult in the family.

(g) To reduce significantly the anxiety level of parents.

(h) Change significantly parents' attitudes toward institutionalization.

(i) Through this plan to devise training methods, techniques, and procedures that can be used by other communities and the institutions.

(j) To work with the public schools to develop curriculum for the youngster retarded of this level. Public schools are more and more being charged with the responsibility of training these retarded until the age of 21. From the age of 17 to 21 this is an untried area for them. We believe a cooperative effort will aid the public schools develop programs as the sheltered workshops are beginning to do for the higher grade retarded late teenagers in school.

(k) To explore who should have the responsibility for such community programs. Should mental hygiene departments begin to think of community facilities such as these under their auspices?

(l) To explore the functions of various professional disciplines in such a program.

B. SIGNIFICANCE

In the last 10 years public-school classes for the retarded have grown greatly (in New York State from 34 to 128 classes for the "trainable" children and from 1,200 to over 1,600 classes for "educable"). In addition, almost all of the more than 600 parents' groups in the United States maintain classes for the "trainable," and some of the "educable." Thus, more and more retarded adults with some early training and a more vocal need for services are beginning to appear. The sheltered workshops, beginning to provide vocational training and sheltered employment, are discovering youngsters unsuited for that program.

The classes for the "trainable," as well as "educable" are now confronted with the problem: How and toward what shall we train the retarded in our

schools from 17 to 21? The sheltered workshops already are asking: What will we do with the young adult not yet, or who never will be, ready for a workshop? Parents say: "I want to keep my child at home, but what is there for him in the community?" Social and State agencies ask: "Whose responsibility is this? What will it cost? Will it achieve the results?"

A program such as we here describe, working with the retarded and their families over a period of time, will, we hope, come up with many of the answers to these questions.

If we can show how a community day center can provide a training program resulting in significant positive changes in adult retardates who presently are considered infeasible for existing community programs; how such services can be used to alter family interrelationships, changing parents' attitudes toward institutionalization or supporting their desire to keep their children at home, it may set a pattern for similar services elsewhere.

An analysis of the professional personnel needed and their functions, costs, transportation, and how to accomplish the desired results, methods, and techniques, will lay the groundwork for voluntary and perhaps State agencies faced with this problem to enter this area of service. By demonstrating their practicability and results, the methods used will, hopefully, aid the public schools to develop programs for the 17 to 21 in this group.

Although the primary aim will be to keep the retardate in the community, we anticipate a secondary result we have already seen achieved with some of the younger retarded. There is no doubt that even with optimum conditions, many retarded will have to go to institutions. It is axiomatic, we believe, that a retarded person, younger or older, is a better citizen in the institution if he is trained in some of the areas indicated. Furthermore, he is less expense to the State in terms of the persons needed to care for him. The child who is toilet-trained is an entirely different problem from the child not toilet-trained; thus, too, the adult who can care for himself completely, knows how to work with others, can contribute to the economy of the institution by making beds, sweeping, etc., is a more acceptable member of that society.

In addition, we hope that some of the techniques developed, and results shown, will be used more hopefully by the institutions for their own populations. An examination of the institutions in New York State, and others we have seen, reveals a dearth of training, other than some occupation therapy, for this group of preponderately middle-grade adults. We hope to show that these can be trained to lead more contributing and meaningful lives in the institutions.

The example of the AHRC Training Center and Workshop is perfectly in point. Through this demonstration, dozens of other workshops were started in the country; the needs of the adult retarded are being translated into curriculum for the "educable" 17 to 21 in public schools; and institutions in New York State, at least, are beginning to parole out some of the retardates for training who previously had no such opportunities available.

C. FACILITIES AVAILABLE

Sufficient space has been made available to the project by the Daughters of Israel, who own two three-story buildings on East Fifth Street, Manhattan. This space includes two kitchens, large rooms for training program, offices, toilets, showers, outdoor play area, and space to set up a complete apartment. Centrally located, it will permit us to get our population from four boroughs.

The association now has an ongoing program, including liaison with 3 clinics in New York City, 11 classes for "trainable" children; recreation and group programs for over 300 adults; a camping program; a sheltered workshop serving about 95 adults a year; parent-education courses; and a guidance, counseling, and referral service. There is a complete staff in the classes, including education experts, psychologist, and speech-developmentalists. The sheltered workshop has a complete staff, including a vocational rehabilitation counselor and social worker, developing group programs specifically for the retarded adult. Our advisory board includes outstanding persons in all the disciplines dealing with the retarded.

Staff from all programs as well as central administration will be available to cooperate in this program. All consider this an integral part of developing a program of services for the mentally retarded.

D. METHOD OF PROCEDURE

It is proposed that between 50 and 60 mentally retarded young adults (male and female) will participate in this program 5 days a week, from 10 a.m. to 4 p.m. The population will be obtained through publicity containing the specific aims of the programs, the waiting lists of the AIIRC, and referrals from the board of education. It is also proposed to try to get some of the population from the department of mental hygiene to see whether the program can bring some now in institutions back into the community. These, of course, would have to be selected for parent cooperation.

Screening for admission

Initial screening will be done by—

1. Questionnaire developed to give us some subjective evaluation by the parents of the retardate's functioning (appendix A). We shall also obtain pertinent data on schooling, medical history, and psychological examinations, if any.
2. Personal interview of the candidate and parents by the social worker. The social worker will take a family history, interpret the goals of the services to the family, and begin to establish an ongoing relationship with the retardate and the family. The social worker will also prepare significant material for referral for the psychological examination.
3. A psychological examination of the candidate will be administered to determine his intellectual functioning, social and personal adjustment. Special emphasis will be on social development as revealed by Vineland Social Maturity Scale in relation to the mental age of the retardate. Before final admission, a staff conference will be held between the director, the social worker, the psychologist, and the work supervisor, at which some initial goals and indicated areas of capability as well as disability will be discussed and set.

The general criteria for admission will be—

- (a) That the candidate be of post school age (approximately 17-25).
- (b) That the primary disability be mental retardation.
- (c) That the candidate be ambulatory and able to take care of his bodily needs.
- (d) That, in the opinion of staff, the candidate is not ready for a vocational rehabilitation program. This is not a black and white matter, but the years of experience that our staff at the sheltered workshop have had with this type of individual leads us to believe that the results of our testing and interviews plus a staff conference may well give us at least the initial setting for this youngster. If proved incorrect, he can be moved from the occupational center to the workshop. The reverse process may also be utilized.
- (e) That the candidate can follow simple directions and communicate, verbally or otherwise. By following simple directions we mean able to respond to a command such as, pick up the broom, or go upstairs and tell Mr. So-and-So to do so-and-so, or let us wash the dishes, or it is now time to make the beds, etc.
- (f) Secondary disabilities, such as epilepsy, blindness, cerebral palsy, etc., will be accepted if not of such severity as to eliminate changes for group participation.

In cases where we are not sure, we are allowing for a period of trial, where we can make some subjective evaluations on the basis of observation within the facility itself.

After admission

We must bear in mind that much of what we will learn will be by trial and error. We have learned a number of things, however, from our other projects as a basis to begin.

1. *Evaluation.*—The objective of evaluation is the assessment of the individual's strengths and weaknesses through observation. Since the individual's ability to adjust is inextricably bound up with total personality, especially for the retarded, this diagnostic process is also concerned with identifying those personal difficulties which appear to limit the individual's performance. The specific objectives in evaluation are (a) to identify the individual's specific assets and limitations, (b) determine whether the individual can perform and the

degree, (c) to test the initial individual goals to some extent and revise or confirm them and form an objective for a program of training.

The means of evaluation are interpretations (a) of objective measures of performance on standardized tasks and (b) subjective records of observed behavior. One of the first things we will do during an approximately 8-week period of evaluation will be to determine whether our initial estimate of the vocational potential of the youngster is accurate. For this purpose we will use some of the evaluation tests developed by the use of work samples in the sheltered workshop rather than aptitude tests commercially available, which we have found to be inadequate for the mentally retarded.

There is general agreement that the attitude, social skills, and work habits of the mentally retarded are at least as important as their purely vocational skills in making an adjustment in the community. In order to observe and draw inferences from such behavior, paid work will be presented to the trainee in evaluation as early as the second week. He will be introduced to such concepts as inspection and quality control, relationship between his efforts, output, and earnings and the material value that the facility as well as our society places upon his labor. The trainees reaction to pay as an incentive will provide staff with some insight into his motivation and general readiness for a vocational goal.

The trainee will also be exposed to other activities in the areas of home-making, grooming, group activities, traveling alone, and his reactions recorded on the behavioral check list to measure, in addition to his abilities in these areas, his social relationships, reaction to peers and familiar and unfamiliar situations. (Appendix B—"Behavioral Check List" now in use that is being further refined and modified.) "The Behavioral Check List" is used both as a coarse diagnostic instrument and to measure change during the evaluation period.

At the end of the evaluation period, the staff will meet again to discuss the data and set tentative goals for training.

2. *Training.*—After evaluation, the population will be divided into groups of approximately 15, by abilities, problems, and potentials. These groups will receive training in the following areas:

(a) Continued social development, including such areas as personal adjustment to the group and work situation, learning to travel alone, ability to sustain interest, the development of independence, and learning good work habits through the program.

(b) The development of skills to make the person a useful member of his household, such as homemaking, cooking, running errands, complete self-care, good grooming, shopping. Many detailed procedures have already been worked out for the sheltered workshop population that, with modification, can be adapted to this population appendix C).

(c) Learning a constructive use of leisure time through recreational group experience in the facility and in the community. This will include learning to participate in organized games, how to join a club, social dancing, crafts, etc.

(d) An ongoing, structured program by the social worker, both individual and group, with the parents to nurture and develop constructive attitudes toward the retardates, their abilities, shortcomings, and future. Building again on the workshop experience with parents, the work essentially will be to establish a carryover from the program to the home as it affects family relationships, etc.

After an initial period of adjustment of the trainee, the social workers will administer a family evaluation index questionnaire, subsequently done annually, in order to test any change in the family index of adjustment while the retardate is in the facility. The Saenger study reveals that where there are families with a low index of family relations were considering institutionalization in 37 percent of the cases, only 4 percent were considering this where the index of family relations is high.

Staff will meet periodically during training to confirm or modify initial goals.

E. RESULTS

1. There will be periodic evaluations of the participants (retarded and families) to measure their growth on the scales we shall develop, as well as through subjective observations. We will observe, too, how many of the population

served will be institutionalized, as against those on the waiting lists who receive little, if any, services.

2. We hope to get subjective evaluations from the institutions themselves, where there is institutionalization of any of the population to see whether these youngsters function any better than those of a similar level of development who have not received the benefit of this facility.

3. We shall observe, too, how the degree of initial functioning, as revealed in our intake and evaluation, affects development of the retardate. We shall observe how progress of the retardate affects future plans of the parents for their children and their attitudes toward institutionalization. Is there carryover to the home? Are changes observed in program the same in household?

4. Such factors as motivation through pay incentives, previously discussed, group pressures through group meetings and clubs, attractive work, the age of the participant, how long the participant has been out of school, etc., will be used to see what effects these have on the personal growth and potential of the trainee.

5. Another important area that we will explore and that may be the subject of some observations will be the retardate's attitude toward the family. All too frequently we speak only of the family's attitude toward the retardate. Our experience has shown that the retardate's attitude toward the family and himself may, in many instances, affect his behavior to such an extent that the decision to institutionalize or not institutionalize may depend on it. Query, Is his attitude merely a reflection on the family—or something different?

6. We shall analyze costs and the role of the individual staff members in relation to the program; evaluate the necessity of staff for other communities; the relation of transportation to the program; and make comparisons against institutionalization costs.

7. We hope to summarize the results of this program periodically and at the end of the program, in such a form as to make available practical methods of training that we have tried and that have succeeded, to point out areas which have pitfalls to other agencies who may want to feel the need of such a program in other communities, in addition to institutions, who hopefully may set up such training programs themselves.

Our experience in a number of semirural areas in this State, indicate to us that such a facility on a regional basis may be a very good thing since any one small community may not have sufficient retardates to support this plan. In those cases, for example, the transportation will be an important element in the success of the operation of the plan.

It is our belief that the program will be of great significance in many areas in the country to the development of services for the retarded.

2. Previous work done on this project

Since 1953 the applicant has operated a vocational training center and workshop for mentally retarded adults. Since 1955, this facility, serving about 95 a year has been partially supported by a grant the Office of Vocational Rehabilitation. The grant expires in May 1960.

In this center, retarded adults are evaluated for their personal, social, and vocational potentials, personal adjustment, and vocational training are offered, and placement and sheltered employment follow. This was the first sheltered workshop for the mentally retarded in the United States. It has been chosen as the prototype for all such projects currently supported by OVR funds, and has served as a model here and abroad. It is visited annually by hundreds of students and workers in the field as well as community leaders seeking to set up a similar service. This service is a research program designed to discover the factors inhibiting the vocational rehabilitation of the mentally retarded, the place in the community of the sheltered workshop in overcoming these disabilities, and what other services are necessary to bring the retarded adult up to his full functioning potential.

The association also has a full recreation and group program for adults under a full-time director. These meet evenings under 18 group leaders and provide a vehicle to learn meaningful and more satisfying use of leisure time and social growth.

In addition, the association's 11 classes serve the mentally retarded from 5 through 17 or older, who are not acceptable in special classes in New York City. These may be youngsters who function too low intellectually or have social or emotional problems making them ineligible for public-school placement.

In this service we see youngsters who will have no service in the community without a facility as here described. In the sheltered workshop and recreation programs, as well, these youngsters appear as adults, all pointing to something different than now being offered. Out of these experiences, as well as those of the special education department of the city of New York, the need for this program and proposal have been shaped. The negative as well as positive results in these programs has given us many leads for what should and possibly could be done.

As a result of these experiences, this association decided to set up an occupation day center and applied to the National Institute of Mental Health for a grant. Pending the decision on this application, however, the pressures for service were such, that the facility was begun on a very meager basis on the premises described previously. Since November of 1958, we have screened, in a preliminary way, about 125 prospective candidates for this service. We have accepted about 40 who attend the facility on a half-time basis, 3 days a week and 2 days the next. During this period, we have been exploring some of the areas of training that we feel will be necessary and some methods of accomplishing the training. The personnel has been limited for 4 months to one person in charge. Recently, we put another on staff as a training assistant. We have also been trying to develop a corps of volunteers, but have found this extremely difficult without adequate professional personnel to training them. During this time, much of the work of making the premises ready has been accomplished. We have experimented with types of equipment necessary. The bugs in transportation, which are quite numerous, have also been ironed out to a great extent.

Our limited experience in the facility itself up to the present time confirms what we have presented in our application, the necessity for more professional personnel, including a psychologist and social worker, and a carefully thought out structure for the program in terms of the result we are trying to obtain. We have also found what seems to be the optimum ratio of 1 training assistant to every 15 to 20 trainees. Even on this sketchy basis, there can be no doubt of the value of the program in terms of the happiness of the candidates and the obvious relief of the parents in finding a place for their children.

The association's programs and their staffs, together with our staff in the central office, are prepared to contribute to the proposed program through cooperation and extension of services, beyond the doors of the facility in order to bring all community forces into play to develop these retarded adults and help their parents.

To our knowledge, no similar program has been tried in quite this way anywhere else in the State. We have, however, found inquiry after inquiry, from the sheltered workshops now being partially financed by the Office of Vocational Rehabilitation throughout the country, concerning the retardate who needs something else than the sheltered workshop. We feel that a network of this type of facility, geared to the needs of the individual communities and in accordance with their financial resources, will supply this need.

Publications

- "Counseling the Mentally Retarded and Their Parents," Joseph T. Weingold and Rudolf P. Hormuth, *Journal of Clinical Psychology*, Mon. Supp. No. 9, April 1953
- "A Sheltered Workshop Operation for Mentally Retarded Adults," Joseph T. Weingold, Office of Vocational Rehabilitation, 1957
- "Some Aspects of Casework Help to Retarded Young Adults and Their Families," Eve R. Mayer, *Journal of Social Work Process*, vol. 7, 1955
- "Work Procurement and Job Production," Max Dubrow, *American Journal of Mental Deficiency*, September 1958
- "Some Different Emphasis in the Role of the Social Worker in a Workshop for Mentally Retarded Adolescents and Young Adults," Jerome Nitzberg, *American Journal of Mental Deficiency*, July 1958
- "The Sheltered Workshop, a Community Rehabilitation Resource for the Mentally Retarded," Prof. Abraham Jacobs and Joseph T. Weingold, Bureau of Publications, Teachers College, Columbia University, financed by an Office of Vocational Rehabilitation grant, 1958
- Joseph T. Weingold is executive director of the Association for the Help of Retarded Children, Inc., New York State.
- Rudolf P. Hormuth was assistant to Mr. Weingold and is now specialist in mental retardation with the children's bureau.

Eve R. Mayer was a social worker with the AHRC Training Center and Workshop.

Max Dubrow is director of the AHRC Training Center and Workshop.

Jerome Nitzberg is the social worker at the training center and workshop.

Prof. Abraham Jacobs is associate professor of education at Teachers College.

3. *Staff and biographical sketches*

Staff, professional.—Director: M.A. or Ed. D. in education: Experience with mentally retarded children, preferably in an administrative capacity in a setting for "trainable children." Experience in experimental programs involving the late teenage or adult retardate.

Our initial selection is Mr. Arnold Fassler, as noted, but we reserve the right to be flexible in this matter. Other disciplines, such as psychology or social work may be equally competent, if they have had similar experience with retarded adults.

Social worker: A senior psychologist, social worker—MSW minimum of 5 years' experience, preferably in child-guidance clinic or clinic for mentally retarded. Experience in a setting working with other disciplines.

To see all families at intake, family history, to interpret goals of the services, to be available selectively to families showing either immediate need for continued case work or to families where family attitude would be an important factor in the adjustment of the group member.

After an initial period of adjustment of the client, to administer a family evaluation index questionnaire, subsequently to be done annually. To make referral, where indicated, to existing social agencies for other services.

Prepare significant material for referral for psychological examination.

Psychologist: M.A. or Ph. D. with significant clinical experience, especially with the mentally retarded. To administer a battery of psychological tests to all applicants; to reexamine all selected applicants semiannually.

To observe program and recommend individual suggestions for group members on the basis of text experiences.

In very selected instances to be available for individual handling of behavior to assist in adjustment to a group setting.

To help set goals for training on the basis of test results, indicating areas of capability.

Supervisor of training: We are considering individuals with three different types of training and would like to experiment with this position.

(a) A person with educational background in the field of mental retardation and industrial arts training.

(b) A person with a master in social-group work.

(c) An O.T. with broad orientation in the field of the handicapped, and willing to work without medical supervision.

Perhaps more important than the kind of training is, as mentioned before, the personal characteristics of the individual selected.

Training assistants: This is a key job in the program.

Warm, understanding, accepting person, related to using himself or herself in a variety of new and different ways. Previous experience may be in special education, community center work, industrial arts with retarded would have obvious applicability.

B.A. or B.S. evidence of educational background, but not essential.

Under direction of director or assistant.

Assume responsibility of groups of 15 to 20 in a structured program.

Conduct training related to travel, homemaking, personal and interpersonal behavior, and educational material.

Supervise use of leisure-time activities, developing under direction, such activities more appropriate to chronological age.

Develop atmosphere of appropriate adult behavior through use of program media. Supervise activities outside the center, such as shopping, going to movies, use of travel facilities, use of other agency recreational facilities, going to the barber, beauty parlor, etc.

Mr. ELLIOTT. Mr. Barden has some questions of you, Mr. Weingold.

Chairman BARDEN. Mr. Weingold, I want to mention this: You are dealing with a subject that is very popular in the U.S. Congress. I doubt very seriously if there are any of the Members here today but what are in favor of that program.

The trouble we confront is "What program?" It is something that appeals to the emotions and the good sense.

As far as I am concerned, I have been fanatically in favor of vocational rehabilitation, and those things that are akin to those programs, but we know we are short on teachers. We know that we are short on teachers of teachers, and we know we have a world of conflicting information on what kind of program is the best program.

It results in compounding confusion. We get letters and they love to use the term "I am president of such and such organization, and I represent a million members." Then you open the fifth letter and you find out that he represents a million members, and has even an entirely different program.

We are not experts. There may be some in Congress, though I do not often run into them. When I do, they are very troublesome.

But you have a lot of organizations. It has an appeal. I think before we ever come out with a reasonable, practical, workable answer that will come up with results, you fellows must get your heads together. We are not going to be very successful as referees as to who has the best idea.

We would like to be in the possession of where is the best program. I make that statement very seriously. I did not start in this trouble yesterday. I have been in it for 25 years. I drop that hint. It is good sense. It is good business. It is wonderful to take one off the expense list and put him on the tax list. Well, if we keep on spending money it will be about as uncomfortable to be on the tax list as it is on the other one. We have to be aware of that.

We, of course, want the States to accept the responsibility they can. The Federal Government cannot carry it all. It certainly should do a lot of work, but there is a general opinion that the Federal Government takes the whole works; though when it does, the tax bill will be around to see our children. Somebody is going to pay for it, that is all, if our Government continues.

I would not like for my grandchildren to be brought up and talk like the little girl who went with her mother to the grocery store and the mother selected her groceries, but then she went by the cash register to pay the bill, the little tot being along with her, and when she paid the corner grocerman the bill he wanted to be nice to the little girl as it was good business, so he took a piece of candy and handed it to her.

The mother said, "Now, Honey, what are you going to say?"

She said, "Charge it, please."

Let's not train them that way. I think that is bad vocational training.

I would like to urge, though, please, to you folks who have given a lot of time, who have become experts, who are recognized as such, that there is very little attitude and very much reluctance, I find, of experts in these fields wanting to give an inch. They are a little bit maybe like myself.

When I conscientiously believe I am right, I am just as right as if I was right. In the interest of getting something done, do not load the whole thing on Chairman Elliott and the rest of these gentlemen to referee and try to get the popular slant on it.

We want the practical slant. I say that.

I mentioned a while ago that the first legislation in the field of the blind, they did a grand job, and they made it possible for the kind of basic legislation to start.

So please help us. That is my plea.

Mr. Chairman, I apologize for taking the time.

Mr. ELLIOTT. Thank you, Mr. Barden, and thank you, Mr. Weingold.

Mr. WEINGOLD. Thank you.

Mr. ELLIOTT. I now recognize the gentleman from New York, the ranking minority member of this subcommittee, to present our next witness.

Mr. WAINWRIGHT. Thank you, Mr. Chairman.

In line with Mr. Barden's suggestion, the little child who suggested "Charge it," when given the piece of candy, there is an organization on Long Island known as Skills Unlimited, and fundamentally the philosophy of this organization is to take the physically handicapped and put them to work in industry so they earn their own way just as the rest of us try to do.

Representing that group today, and who will tell us about it, is Mrs. David Weld.

Mrs. Weld, would you present yourself to the committee?

STATEMENT OF MRS. DAVID WELD, SKILLS, UNLIMITED

Mrs. WELD. I certainly don't represent a million members. In fact, our workshop is very small, and the only way it would have any significance for you, I think, is if you could argue from the particular to the general.

It is a vocational rehabilitation workshop. We feel physical and emotion rehabilitation is done by other agencies in the county, but when a client is ready to go to work, we are the only outlet in Suffolk County to whom they can come.

From the beginning, the board realized that Skills was too small an outfit to take care of the rehabilitation needs of everyone in Suffolk County, so we limited our field to the physically disabled.

We planned to take only physically handicapped candidates, but, in spite of that determination, we have had to change our policy in order to maintain maximum service to the community.

I might say that this workshop was started originally by the Council of Social Agencies in Suffolk County, so the motivation was quite pure.

In or near Suffolk there are some outlets for the simple physically disabled who need a minimum of vocational training. They can be placed directly into business or industry by the DVR or the SS.

They may develop self-employment or even travel to a nearby industrial workshop where as there are no outlets in Suffolk for the so-called unemployables, the severely disabled, postpsychotic or the mentally retarded except at our workshop, Skills, Unlimited.

In a period of about 4 years, 40 percent of our clients have had emotional or intellectual disability. The local DVR, unofficially, says that only 50 percent of the people referred to them nowadays have emotional or retarded disability, whereas the people we get from the DVR are more than 75 percent emotionally retarded.

We think that is because we are the only facility for that group.

We have had 169 clients go through the shop, and 33.7 percent of these, which is more than a third, have become employed or found jobs outside of Skills, Unlimited, as a direct result of their training with us.

Of course, we still have a great many of them with us because we feel that there is still a chance that we may be able to place them outside if they get a little more experience.

We consider this a successful operation.

The reason I am telling you about it is that it simply couldn't have existed without DVR funds. Almost every one of our clients is referred through DVR.

A few of them through voluntary agencies who support them to a certain extent.

We have had a grant from the State DVR for expansion, but Skills, Unlimited, just could never have come into being without DVR money.

Our first recommendation to the committee would be to continue the DVR and OVR funds and their availability to small outfits like us for rehabilitation, vocational rehabilitation.

Our next recommendation is less specific and grows out of a problem which we meet constantly at the workshop.

The young people who come to us for training, and we have a large percentage of young people who come, either straight from high school or are about that age and have never had much education or have never been employed, most of them have spent many years in special classes, but we find that they are simply not educated up to their capacity. This is particularly true of the retarded group. Even the educable retardates with an IQ of over 50 have not been taught to count or to tell time or to make change.

We know that these skills can be taught, and they are absolutely essential for us before we can start a client learning a vocational aptitude.

Apparently, the school districts cannot raise funds for capable teachers or provide adequate space for this kind of group.

I find all different chronological ages together and that develops emotional problems.

Skills, Unlimited, is very conscious of this need.

Funds available for improved education of the young handicapped, particularly retarded, would very much improve their chances of subsequent vocational training and self-sufficiency.

That is our second recommendation.

I could not resist putting this in. Although it has nothing to do with the allocation of funds for you, one field in which we could use help and all workshops like us could, is that we have trouble getting suitable contract work for handicapped workers. We are not looking for handouts.

It is obvious that a workshop does have to maintain the highest quality production to exist at all. But we thought perhaps if the Small Business Administration had their attention called to the fact that small workshops for the disabled needed contracts, something might be done at a Federal level in that way.

I have a detailed report of 150 cases made out by our executive secretary, but I have summarized that more or less.

I might leave it with you.

Mr. ELLIOTT. The Chair recognizes the gentleman from North Carolina.

Chairman BARDEN. Mr. Chairman, could that be placed in the record?

Mr. ELLIOTT. Would you place the detailed analysis of 150 cases that you mentioned into the record as part of your testimony?

Mrs. WELD. Yes, sir.

(The list referred to follows:)

ANALYSIS BY MRS. RITA ZIELENSKI, EXECUTIVE DIRECTOR, SKILLS, UNLIMITED, INC.

The following is a brief analysis of 150 cases of handicapped persons given training and employment by Skills Unlimited, a vocational rehabilitation workshop in East Islip, Long Island. Although no complete, scholarly study of these clients has been attempted, there are certain facts and conclusions which emerge very clearly.

The incidence of various disabilities found among the 150 clients is as follows:

Mentally retarded.....	19
Emotionally disturbed.....	17
Mentally retarded and emotionally disturbed.....	5
Mentally retarded and physically disabled.....	15
Emotionally disturbed and physically disabled.....	7
Total.....	63
Physically disabled.....	87
Total.....	150

Thus it can be seen that in a shop originally intended to serve the physically handicapped only, 42 percent over a 4-year period were handicapped by a mental or emotional disability. This proportion represents diagnosed cases; there were many clients referred to Skills Unlimited as strictly physically disabled clients; experience in the workshop later revealed an emotional or intellectual disability. Although Skills Unlimited started out to serve the physically disabled, the demands to offer service to this 42 percent (and more) were so great that we tried to meet the need with specially devised programs where possible. The Hempstead office of the State division of vocational rehabilitation unofficially states that 50 percent of its present caseload is comprised of the postpsychotic and the retarded. At the same time it is significant to note that 75 percent of the referrals to Skills Unlimited from the DVR are clients with these disabilities.

Of the 63 clients who suffered from these mental disabilities, 31 were over 21 years of age and 32 were under 21. None of the group under 21 had finished high school and most had not finished elementary school. Among the 87 physically disabled clients, 15 were under 21 and none had finished high school.

Of course the significance of this experience with these 150 clients lies not in the figures but in the results. It is the consensus among the workshop staff and also the referring agencies that all of the emotionally disabled were helped to some degree: several found jobs on the outside, some sought much-needed hospitalization or special therapy; all left the shop with new courage to travel, seek better jobs or just to change the environment in which the condition originated. On the other hand it is the consensus of the workshop staff that the results with the retarded were not as favorable. The reason in every case was because the retardates come to us with little or no preparation for even the simplest kind of vocational training. None of them could read or write other than their own names; none could count to 100 accurately and very few could count at all. None could tell time, make change, weigh or measure. These were educable clients who could reasonably be expected to have mastered some limited level of competence in these areas. In addition, all were so distractible as to be unable to learn in a group situation. In addition we found that all of these young retardates had been in ungraded special classes, some in groups including children from the ages of 10 to 17. There were, of course, emotional

conditions resulting from this procedure of grouping retardates of all ages in one special class.

As for the young people who had only physical handicaps their schooling varied widely but in every case would seem inadequate. Some had classes during their stay of from 5 to 10 years in a hospital; some had received home tutoring from time to time; those who were ambulatory attended regular classes up to eighth grade. There seem to be little or no high-school facilities available at the schools for nonambulatory pupils.

The recommendations we draw from the foregoing experiences are as follows:

(1) Funds should be made available for more workshop facilities for the post-psychotic. There are several ways in which this could be done: expanding present workshop facilities; adding workshops to the present mental-hospital programs; providing funds so that new workshops can be established. In order to contribute some new knowledge to this aspect of rehabilitation Skills Unlimited has applied to the Office of Vocational Rehabilitation for funds to do a 5-year research study on the benefits of establishing a workshop in a convalescent home for emotionally disturbed veterans.

(2) Funds should be made available for more special teachers, for additional classroom space and other facilities for educable retardates. If the retardates in this group could be taught the basic skills already mentioned here, within their own limitations, they would have much greater hope than they have now of being trained to become self-supporting in whole or in part. A rehabilitation workshop cannot train retardates to count, write, tell time, etc., and still train him for a job. The preparation must be in the schools which today are not adequately staffed or equipped to do this job thoroughly.

Mr. ELLIOTT. Thank you very much, Mrs. Weld. Your testimony was very helpful to the committee.

Mrs. WELD. Yes, sir.

Mr. ELLIOTT. Our next witness is Miss Joan Abajo, teacher at the Lexington School for the Deaf.

Miss Abajo, we are very happy to have you here.

STATEMENT OF JOAN ABAJO, STUDENT, LEXINGTON SCHOOL FOR THE DEAF

Miss ABAJO. Mr. Chairman, members of the committee, I greatly appreciate the opportunity to speak to you with regard to the pressing need for the legislation presented in Resolution 494.

Most of the testimony we have heard thus far concerning the training of teachers for the deaf has been presented from an administrative point of view.

I speak to you as a teacher in training. Why have I chosen this field? This work is challenging, offers enormous inner satisfaction, opportunity to contribute to the growth and development of other human beings, but most important, is the reward, the reward of watching children born into a silent world learn to communicate, not perfectly, but effectively, in a hearing world.

Why, then, are there so few teachers available in this exciting field?

Is it the year of graduate work that is necessary to become specially trained?

I think not. But it is the money it costs to become specially trained.

I have worked for the past 2½ years as office manager at Mademoiselle magazine trying to save enough to take a year of double loss. Yes, a double loss for during the year in training we have no income and yet at the same time we are paying out.

Some of us go into this graduate work directly from college. Many of us are willing to obligate ourselves with loans which will take a

number of years to repay; many of us are willing to accept grants and scholarships from local organizations which require our services in their schools for a number of years.

Yet, because the number of schools that have training programs is so limited and the number of trainees those schools are able to accept each year is even more limited, we consider this year a real privilege.

Lexington School, the originator of the language method, has had a training program since 1906, and in more than half a century has graduated only some 400 teachers. There are only 12 in this year's class.

With more space and housing facilities our school alone could train three or four times our number.

The actual cost of this year is \$2,400 per student, at a minimum. Tuition costs \$1,400, not including books and necessary materials.

The cost of room and board at Lexington School is \$1,000. Where else in New York City could one live on that small amount?

Our class represents 11 States, some girls coming from as far away as California, Colorado, Utah, and the State of Washington, thus, there are heavy travel expenses.

Believe me, we aren't complaining for 1 minute. We are so very grateful and mindful that every available advantage is being offered us. We do regret that many times our number can't have these same advantages.

Indeed, we are flattered with the deluge of letters from all over the country offering us employment, but, at the same time, we are depressed by the realization that there just aren't enough trained people to fill a fraction of these jobs.

It is the administrators and teachers themselves who work laboriously training us, in addition, of course, to their own responsibilities. There is no existing personnel.

Naturally, with the increase in young men and women able to be trained—assuming this bill is passed—there will come the need for personnel. Perhaps some of us will be among those who will go even one step further and become administrators of training programs.

While you gentlemen tour this country, holding hearings, may we hope that you take time out to visit as many schools for the deaf as you can, see this progress being made, the strides taken by these children, for I believe that this firsthand observation will enable you to evaluate more accurately the gravity of the situation.

I would like to extend to you an invitation to visit Lexington School while you are in New York City.

Deafness is not a visible handicap. Most of us originally thought of deaf and dumb as being synonymous. These children are not dumb. They are of average intelligence, often extremely bright children, but are unable to communicate their thoughts and ideas without special help. With this help they have the chance of becoming first-class citizens, leading healthy, relatively normal lives in a world full of sound that they will never hear.

They become gainfully employed, have happy homes and marriages. I do hope you come to Lexington and see for yourselves.

Thank you.

Mr. ELLIOTT. Thank you very much, Miss Abajo.

Are there any questions?

If not, your testimony will be very helpful and we appreciate it a great deal.

Has Mr. Lee C. Dowling arrived yet?

Has Dr. J. M. Brady arrived?

Has Dr. Marion Langer arrived?

Is Mr. Jack Rothman, president of the Council for Exceptional Children, Cerebral Palsy School, Roosevelt, N.Y., present?

Mr. Rothman, would you testify now.

STATEMENT OF JACK ROTHMAN, PRESIDENT, COUNCIL FOR EXCEPTIONAL CHILDREN, ROOSEVELT, N.Y.; ACCOMPANIED BY EMIL A. LOMBARDI, PRINCIPAL, CEREBRAL PALSY SCHOOL, NEW YORK, N.Y.

Mr. ELLIOTT. Mr. Rothman, we appreciate your willingness to go on a bit ahead of time. We understand that you are president of the Council for Exceptional Children, Roosevelt, N.Y.

Would you introduce for the record the gentleman who accompanies you?

Mr. ROTHMAN. This is Mr. Emil Lombardi, principal of the Cerebral Palsy School at Roosevelt, and the past president of the Council for Exceptional Children at Roosevelt.

Mr. ELLIOTT. You may proceed.

Mr. ROTHMAN. We have been discussing this since we received your gracious invitation to attend and, of course, you probably will hear a lot of some things we have in mind from some other people.

But what we were particularly interested in is the expansion of public services to accept all types of handicapped.

We are particularly concerned with the handicapped who leave the schools at the age of, say, 18, but have no place to go. In other words, we give them as good an education as we possibly can, but they just don't fit into our economy.

They really should not be institutionalized and they really can't work.

What happens to these people after we have given them an education, spent a great deal of money on them?

What happens to them? Do they stay at home?

We feel there should be a midway, a half-way facility, where the child, or, if it is a grown up, can attend a school where he will be exposed to social and vocational experiences in a limited way, so that we can carry on some of the work that we have done and have not succeeded in doing in a regular public school, which means that these children, these teenagers by now, would not have to go into public institutions, would not become public charges, and could stay at home, because in most cases the parents would be able to put up with the child if the child were away from home, say, 4 to 6 hours.

But we have to give them meaningful experiences in this area so that possibly, and these are all suggestions, of course, the school can be run, say, by an educator with the facilities of a psychologist, of a social worker, of a medical doctor, a vocational rehabilitator with a team approach.

Perhaps the child needs another 2 years of schooling, and by then he might be able to get some sort of a vocational job.

— But where the responsibility drops off at 18 or 19 without anything else, would mix it up.

The child has been in school and has been worked with and everything else, and all of a sudden there is a sharp drop. All of a sudden he is put out.

What happens to him? Where is the planning? There should be some type of planning that goes on beyond this.

But it should be a realistic planning, a planning that is open to all types of handicapped children and not where you have to have certain restrictions and so on because of your handicap, but where a child can go, so that we don't have to place a child in an institution.

So that we can utilize him.

It has to be a public type of thing, which is available to all handicaps.

Mr. LOMBARDI. Mr. Elliott, if I may add or go a little further on what Mr. Rothman has indicated, although we are aware, as he mentioned, that others may come in here and have similar ideas, we want to support anyone who possibly had a similar factor concerning what we call a midschool.

We were in hopes if any grant might possible be provided on the Federal basis for this type of midschool, as Mr. Rothman explained before, and I would like to go a step further, we have a group of handicapped individuals within all our communities, and in some communities more so than others, and these people are not qualified for homebound training, do not qualify for hospitalization type of programing, nor do they belong in a school.

Most times they are considered for residential institutional care.

It is a feeling that there is a possibility with this midschool that we can overcome this problem of sending them to institutions and to do what we can in a very limited way, through this midtype school, whether it be a recreational plan or medical plan, we are not certain unless some type of grant were given to service the needs and the qualifications that necessarily have to be taken into consideration for such a plan.

This is the only thing that we would like to offer from our particular chapter.

Mr. ELLIOTT. Thank you very much, gentlemen. Your testimony will be very helpful to the subcommittee. We appreciate it very much.

Mr. ROTHMAN. Thank you very much for having us.

Mr. ELLIOTT. Has Mr. Lee C. Dowling, Director of the Joint Legislative Committee on Mental Retardation arrived yet?

Has Dr. J. Morrison Brady arrived yet?

Dr. Marion Langer?

Mr. Richard T. Gilmartin?

We have heard about 15 witnesses, so we will recess now until 1:30.

(Thereupon, at 12:05 p.m., the subcommittee was recessed, to reconvene at 1:30 p.m. same day.)

AFTER RECESS

(The subcommittee reconvened at 1:30 p.m., Hon. Carl Elliott (chairman of the subcommittee) presiding.)

Mr. ELLIOTT. The subcommittee will be in order.

May I say that we have about 15 witnesses to hear this afternoon, and we want to try to complete this series of hearings this afternoon, if possible, so it will be necessary that we again limit, as best we can, the time taken by each witness.

Also may I say that the subcommittee is extremely happy to have with it this afternoon the gentleman from New York, Mr. Ludwig Teller, who is a Member of the U.S. House of Representatives, representing the 20th District of New York. Mr. Teller is interested, I might say he is vitally interested, in the subject matter of the hearings before our subcommittee. He is the author of bills on this subject.

We are happy to have you, Mr. Teller. I wonder if I might recognize you at this time to say a word in behalf of your views on this matter?

STATEMENT OF HON. LUDWIG TELLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

MR. TELLER. Thank you, Mr. Elliott. I am delighted to be here. As you have pointed out, I do have at least two bills on this subject, that is to say, Federal aid for emotionally disturbed or mentally ill children.

I think that at the present time our Federal statutory intervention in this field can stand improvement. The statutes in the main seem to deal primarily with the retarded children, and the Federal Government does a job in that field, a job which could be expanded and refined, but at least there is a measure of Federal intervention in that field.

When it comes to the emotionally disturbed or the mentally ill child, the Federal Government lacks vision, and it has failed to take the kind of intervention which is so desperately necessary in this field, particularly because by the expenditure of a small amount of money, a tremendous measure of rehabilitation can take place.

In the case of the mentally retarded child, the prospects for rehabilitation are meager, but society can get tremendous gains from young, gifted children who are emotionally disturbed or mentally ill. So it is my hope that as a result of these hearings we will be able to spotlight the need for Federal intervention, not merely by the spending of money, but for purposeful outlay, by providing funds for the training of teachers in this very important field, and for the development of programs for the mentally ill or the emotionally disturbed child.

These hearings are very significant, particularly if they develop a better understanding of this gap in the Federal intervention in this field. I congratulate the subcommittee on its work.

MR. ELLIOTT. Thank you very much, Mr. Teller.

Chairman BARDEN. Mr. Chairman—

MR. ELLIOTT. Mr. Barden.

Chairman BARDEN. My friend has made such a nice statement that I hasten to claim him. He is a member of the full committee on this subject, of which this is the subcommittee.

MR. TELLER. I am delighted to see that the chairman, who has had such a tremendous job of work in the last session, has nevertheless

found time to come here and to be here. We are honored by his being the chairman of our distinguished committee.

Mr. ELLIOTT. Thank you very much.

Our next witness is Dr. Marion Langer. Is Dr. Langer here? Please come forward, Dr. Langer.

Dr. Langer represents the American Orthopsychiatric Association. We are happy to hear you, Dr. Langer. If you could, confine your testimony to about 10 minutes. It will be very helpful.

STATEMENT OF DR. MARION LANGER, EXECUTIVE SECRETARY, AMERICAN ORTHOPSYCHIATRIC ASSOCIATION

Dr. LANGER. I am all prepared.

Mr. Chairman and gentlemen, the American Orthopsychiatric Association is pleased to respond to the request of your committee and to give its opinion on some of the problems of special education and rehabilitation. The American Orthopsychiatric Association is concerned with the mental well-being of the individual at all ages, but chose to limit its consideration in this statement to children for two reasons: (a) it assumed that many other organizations in the field would present data with respect to special education and rehabilitation programs for adults; and (b) basic to the entire problem are the preventive aspects of such programs and this necessitates primary consideration of the needs of the handicapped child.

The American Orthopsychiatric Association has a membership of more than 1,600 psychiatrists, social workers, psychologists, and other professional persons including educators, sociologists, et cetera, whose work and interests lie in the study of personality and behavior and the treatment of disorders thereof.

Membership is limited to those whose activities promise an enhancement of the association's scientific objectives and whose qualifications meet those set by the association. We unite and provide a common meeting ground for those engaged in the study and treatment of problems of human behavior; we spread information concerning scientific work in the field of human behavior, including all forms of abnormal behavior.

We are listed as an educational and scientific society. It is from that standpoint that we speak.

THE BACKGROUND OF THE PROBLEM

(1) The extent of emotional and mental illness and its problems are of great significance to all of us. According to present indications, 1 out of 12 babies born in this century will enter a mental hospital. It is estimated that there are between 9 and 13 million people with nervous, mental, or emotional troubles. It is generally accepted that the factors influencing breakdown and that become apparent in the emotional ills of adults begin in childhood.

(2) Estimates as to extent vary, but most authorities believe that the incidence of mental retardation is about 2 percent of the general population.

(3) Mental retardation is a condition which results from a combination of biological and environmental factors. There are literally

dozens of different medical conditions which can cause mental retardation. All types of mental retardation are further influenced by social, economic, educational, and emotional factors.

Despite the relative inability of medical science to cure mental retardation resulting from cerebral defect, authorities agree that most retarded children can become useful, productive individuals if they are given suitable education and training, and are accorded the same degree of social acceptance as other children with different types of disabilities. For example, only a very small proportion of even the severely brain-damaged children are not capable of learning self-care.

(4) It has been believed for too long that the provision of State training schools or some few special classes in the public schools solves the problem of all mentally retarded children. Actually, a relatively small proportion of all mentally retarded children require costly institutional care.

Yet in the absence of special facilities in the community such as special clinics, adequate school and recreational services, guidance and counseling, vocational training and job placement, many mentally retarded children are never trained to utilize their hitherto overlooked capacities for productive living and potential contribution to society.

(5) We have paid for our neglect of these children not only by having to maintain and to support large and costly institutions for their permanent care, but also through the loss to the community of these individuals' potential social contribution.

(6) Most mentally retarded children can become valuable assets in their homes and in the community if they are given the proper help and training. It is obvious that the rehabilitation of the retarded child is a many-sided venture cutting across the lines of responsibility of many disciplines—medicine, education, psychology, and social work.

Clearly, this is an area in which the community itself must begin to see its responsibility beyond the maintenance of some special classes and residential institutions. In this way, the 75 percent of the retarded group who, according to former Surgeon General Scheele, are capable of being rehabilitated, will become productive, contributing members of the community.

Whatever the legal or social designation, whatever the clinical diagnosis, the emotionally disturbed child can be described in the following terms:

They are children who are frightened, fearful of human experience; children who have not had opportunity to discover the gratification of positive accomplishments necessary to their healthy growth. They may be impulsive, unable to tolerate anxiety, frustration, or competition, and may react with withdrawal, or aggression, or other defensive measures to protect them from their feelings of inadequacy and insecurity.

They may be anxiety-ridden children who have never known the security of consistent living with people and control of their behavior. They are children who have experienced too little love or too much neglectful indulgence. Many come from homes not broken by poverty essentially, but more often by situations in which parents, either because of problems or other difficulties, are unable to cope with the demands of parenthood. Often the sheer weight of the child's prob-

lem and lack of adequate resources to help renders the parents unable to cope with the child.

Many of these children have had brain damage, many have had little stability or continuity in their significant relationships with people, or they have been brought up by parents too upset themselves to permit normal identifications to develop; or they may have had a combination of both.

In the treatment and education of these children, they must be exposed to a variety of experiences with children and adults; to constructive experiences and activities in which there can be accomplishment and a sense of gratification; in which they can have the feeling of being wanted, respected as individuals, and loved; in which there can be routine and framework and the kind of consistent regime or controls they so desperately need.

THE NATURE OF THE PROBLEM

The retarded and mentally ill cannot be treated as a homogenous group, nor can recommendations of a general nature be safely made. Each child must be treated as an individual with all his possibilities. There is much we do not know about these children. It is often difficult to distinguish between a retarded and a mentally ill child. Many errors can be made in diagnosis to the detriment of the child and society. Also, retarded children, even brain-damaged children, have an emotional life. Often emotional disturbance of all degrees is superimposed on retardation and not recognized. Two points are basic:

(1) In any community approach, it is first necessary to determine the size of the problems already known, to identify, diagnose, and classify them.

(2) To differentiate these problems according to two main groups: those who are seriously ill, need and can use a community-based clinical service, and those who may or may not be diagnosed as seriously disturbed, but who can and should be served by a variety of other professional and supportive services.

Placing a damaged child in a setting where he has opportunity for normal growth experiences is in itself a form of treatment. Real experience and real relationships come out of the process of daily living as it may be planned and directed in accordance with the therapeutic needs of the child.

There has been too little willingness to try with these children to experiment with different methods of care. It has been more characteristic for agencies and schools in the face of limited resources and many pressures to treat them routinely. Following are some of the present understandings generally accepted:

(1) Presently available estimates of the number and types of children needing various forms of care and treatment are inadequate; no sound estimate of the incidence or prevalence of particularly psychiatric disclosures requiring such treatment can be made. However, it is known that the problem is massive and will grow with the population growth.

(2) There are at present no statistically valid data on the number of emotionally ill or mentally retarded children needing institutional treatment; criteria for the judgment of the need for institutional

treatment against other forms of therapy are not established; the effectiveness of all forms of treatment of the mentally retarded has not been validated.

(3) It is known that seriously emotionally ill children are being kept in detention homes, jails, and other inappropriate places; and that mentally retarded children are frequently misplaced.

(4) Not enough professional, technical, and related personnel are being trained. We are not deploying and utilizing existing personnel most efficiently. Not enough sound opportunities are available within which new methods of training and utilization can be tried.

(5) The existing services and agencies represent an unplanned and uncoordinated patchwork. There is no major force available to act as a catalyst toward coordination and planning.

CONCLUSIONS

(1) There is as yet no satisfactory definition or classification of the basic community problems to which a community mental health program strategically should be directed. This is the reason that so far we have no usable epidemiological data about the community-wide size and characteristics of mental health problems. The only reasonably clear segment of the problem about which we have data is in the mental hospital field. Here we have many facts about people who are severely ill and disturbed.

(2) Lacking a concept of a program with a communitywide problem focus, we have no basis for evaluating the impact of mental health services upon the community's problems. Among evaluation studies of community mental health services, it might be noted that there is a general lack of research within any of the behavioral sciences specifically directed to communitywide results, a lack of administrative and planning research with an accompanying action program.

(3) The nature of what constitutes a mental health program is made even more ambiguous and confusing by the fact that under many different behavioral disciplines there are an equal number of claims to comprehensive community goals.

The basic services, public and private, which we have created, their traditional and uncoordinated community design, represents a formidable handicap to a unified attack on the problems involved.

None of our present services is organized to produce comprehensive diagnosis and treatment.

Under existing pressures and lack of existing services children are often buffeted from one service to another. Children who might be kept at home or in a community institution are in all too many instances placed ultimately in long-term institutional care possibly because the agency to which they are known, usually by inadvertence, did not have available a complete service.

No completely coordinated use of our existing knowledge will be achieved until we establish better unification of patterns of service. Greater precision is needed if we are to (a) meet the problems; (b) achieve desirable therapeutic goals on a communitywide basis; and (c) to use mental health resources effectively in the directions of greatest need.

Emphasis must be placed on (a) early diagnosis and treatment; (b) making all services available on a coordinated basis to the children and families who show severe pathology.

It is suggested that four modes of basic services are needed:

(1) An in-patient psychiatric service for (a) those who can be treated and returned early to community life; (b) those too ill or not amenable to short-term, in-patient care.

(2) An all-purpose mental health service to identify, diagnose, and treat disturbances needing treatment on an out-patient basis.

(3) A multipurpose professional service for families and children to meet the problems of adjustment and offering casework, group work, child placement, day care, and related services.

(4) Special educational services available to each school system. Classes should be manned by specially trained teachers; clinical personnel should be available to help. Program should be prescriptive and coordinated with other services indicated above.

Aside from the hazards of existing traditions, which prevent coordination, a great bar to ultimate achievement of a sound pattern in any community is the absence of proper educational facilities in adequate number for the children under treatment.

The in-patient facilities generally have special educational programs. However, many children who might otherwise be kept at home or in open institutions are sent to in-patient facilities. The public schools have developed educational facilities for retarded children but for the most part not for emotionally disturbed children.

Children who might live at home and receive clinic or private treatment are often placed in foster homes, then open institutions, then in closed institutions. Recently, in a few States some day-care programs for the disturbed child have been initiated. If a total day of care away from the parent could be planned in conjunction with the proper therapies as part of most community programs, the child might have been able to live in the community and to be treated more economically from many standpoints.

Very little is known, because there has been a dearth of experimentation about educational programs for these children.

H.R. 3465

(1) The great interest and concern for the disabled by public and private welfare agencies, public health programs, medical programs, and vocational rehabilitation programs has resulted in a complex system of public and private programs frequently overlapping with respect to clinical services and professional personnel used.

(2) The several programs have had different financing bases, some of which has impeded development of high quality services. For instance, the 1956 amendments to the Social Security Act gave recognition to the need for the importance of services to public assistance recipients that provided less Federal matching than other similar programs.

(3) Each system developed social, psychiatric, and psychological concerns which bind them together, but they have not yet found the proper ways and means of coping with institutional patterns, tending

to deprive people of a free flow and full range of integrated and unified services.

RECOMMENDATIONS

(1) Therefore, we recommend that all existing programs at the Federal level, including vocational rehabilitation, social security, and public health, be allowed to continue and develop their programs but that no one of these agencies be given a new responsibility such as described in H.R. 3465. Rather, we propose that new legislation be developed with authorization and funds given directly to the Secretary of Health, Education, and Welfare to unify the type of demonstration designed to coordinate the several programs now suffering from proliferations caused by legal problems on the one hand, and by the large number of specialized agencies devoted to a particular handicap, on the other.

We propose that the Secretary be provided with proper advisory and interagency machinery designed to not only improve present programs, but which might have the potential for unifying and coordinating our preventive and therapeutic resources. This would be a step toward consolidating our gains and arriving at better methods to pinpoint the nature of problems and to attack them with integrated force, rather than with present uncoordinated forces and broadsides.

Because there is so much unclarity as to the nature and meaning of "rehabilitation" and because the several programs all have engaged in "rehabilitation," assigning the function of "rehabilitation for independent living" to one agency might tend to confuse rather than clarify; to scatter further the already scarce resources and to increase the hindering jurisdictional difficulties.

(2) That the Congress, together with the Department of Health, Education, and Welfare, using appropriate councils and studies, including those of this committee, move in the following directions by appropriation and program:

(a) A massive approach to the recruitment and training of professional personnel in the child rearing and treatment fields. These include psychiatrists, special education teachers, social workers, psychologists, and a variety of other personnel utilized in institutional treatment and preventive programs.

(b) Aside from basic research, to encourage operational research and experimentation designed to eliminate outmoded and overlapping structures at local operating levels, so that dollars and personnel existing at any one time can be used with maximum efficiency.

(c) Increase Federal concern, not only with basic research, but emphasize research on methods and machinery for prevention.

We are very appreciative for the opportunity to have presented our point of view and we are certain that the members of our association, in their several capacities, will be happy to assist the committee or the Federal Government agencies in any way. The association will be glad to receive requests for advice or assistance and transmit such requests to its members.

Mr. ELLIOTT. Thank you very much, Dr. Langer.

If there are no questions, our next witness is Miss Arlene Gilbert, field consultant of the State Charities Aid Association.

**STATEMENT OF MISS ARLENE GILBERT, FIELD CONSULTANT,
STATE CHARITIES AID ASSOCIATION**

MISS GILBERT. You sort of saved me, Mr. Elliott, my first sentence, but I think I should say that although I am here in my capacity as field consultant of the State Charities Aid Association committees on children and public welfare, I represent Mrs. George Govern, of Seneca Falls, N.Y., president of our State committee.

As these hearings have been called to discuss needs in the field of special education, it seems in order to include a discussion of special education which can prevent handicaps as well as that which offers rehabilitation. The handicaps we refer to here are social rather than physical. The group of children we refer to are perhaps the most severely handicapped in the United States as far as education is concerned, children of migrant workers. The schooling of these children is so interrupted by the constant movements of their families that it is almost impossible to compare their education with that which we expect as a bare minimum for our children today.

It appears to be assumed that they can pick up where they left off at each move, enter a new school at their grade level, and reweave the dropped threads into a fabric which can be stretched to meet specifications. Yet we know this does not work. Records indicate that relatively few migrant children attend school regularly. Studies have shown that most of these children are far below grade level and that their school achievement generally is under fourth grade, the attainment established as a minimum standard for literacy in the United States.

It is reported by the U.S. Office of Education that the migrant group has the lowest educational attainment of any group in our Nation. It has been shown that there is no inherent defect in the abilities of these children, that even IQ ratings improve with better schooling. Many factors add up to a deprivation for children of agricultural migrants of educational privileges equal to those of other children. As a result of these factors, children of migrants enter school later, attend fewer days, show greatest retardation, achieve the least progress, drop out of school earliest, and constitute the largest single reservoir of illiterates.

Some of these factors are deeply personal—lack of interest of parents in the education of their children, needed extra income children may earn, and so forth. Although it is difficult, and perhaps impossible, to handle problems of this sort through legislation, it is reasonable to expect that special education and special teachers might help to overcome some of these things, parental apathy or helplessness, even as with parents of the physically handicapped.

More important for the consideration of this committee are the facts that many schools and teachers fail to understand and provide for the special educational problems of migrants. Even when the migrant children are welcomed into the school, there is the problem of adjusting school experiences to their immediate needs.

The school is faced with the problem of identifying the academic achievements of each migrant child and placing him where he can make the most progress. The teacher whose classroom may already be crowded is challenged to do everything possible to help these chil-

dren, as well as the regular pupils, live happily in the school as they work to improve their academic achievements.

This requires much individual teaching and personal attention. It may also require teachers especially trained to cope with language and even cultural differences. Teachers in New York State schools have reported some of the simpler language stumbling blocks. A youngster can't add numbers, as the class has been told to do. He doesn't know about adding. He totes numbers. Yet, despite this above-average need for personal and special attention, these children receive rather less than the average amount.

There is a small community in New York State where, instead of taking these children into the regular classrooms, a single teacher is sent out during the fall months to handle between 40 and 50 migrant children, often ranging from first to eighth grade, in a single class. These children do not mingle at lunch or at recess time with other children in the community, as their classroom is quite isolated, not only from the school but from the town itself.

Unless the schools accept these children as having a right to their facilities, and even to special facilities provided for their short-time stay, we cannot pretend to be offering them equal opportunities or improved prospects for overcoming the special handicaps they face.

We are concerned here with helping the handicapped achieve a greater degree of independent living. Yet the opportunity to prepare for occupations other than those in agriculture are few for most migrant children. In most schools, vocational guidance programs are scheduled over a school year. Migrant children who attend for only a brief period in each school may not ever get a basic education, much less any of the training, testing, group guidance an individual counseling which is normally spread out over the total period, because they are always behind other children who have had all the services available, and because they do not know how they can carry out any plans they made, they tend to feel that vocational planning is useless.

Migrant children would seldom reach the senior grade in high school, where the year-round program is available in the school for those seniors entering the labor market after graduation. It is not only true that they seldom would reach the senior year; they seldom do. Less than 10 or 15 percent of migrant children ever reach high school, and a smaller percentage finish.

Despite these odds, one hears sometimes, as recently in newspaper publicity, of the rare case, in this instance two cases, of girls, both children of migrants, having entered a college. We think that more basic elementary education for these children is certainly essential, and whatever special assistance is needed to assure this.

In closing, we would like to point out the recommendations made and published just this last spring by the Mid-American Conference on Migratory Labor, which was cosponsored by the Council of State Governments and the President's Committee on Migratory Labor. Their recommendations covered children and youth, housing and sanitation, public health and public assistance, governmental and community responsibilities.

We refer only to the eight recommendations concerning children and youth:

(1) That compulsory education laws be enforced for the migrant child as well as for all other children.

(2) That continuity of educational records about migrant children be available to schools along the migrant route, at least a simple, uniform card to be developed for each child to carry. A sample may be secured for adaptation from the U.S. Office of Education. At best, a folder of guidance material should be sent on by the school. Studies of exchange of rerords in the mid-America schools should be encouraged.

(3) That because the influx of large numbers of children in some school districts places an unusually heavy burden on the school budgets, the States and the U.S. Office of Education should give consideration to the reimbursement of local school districts on a basis similar to other special educational problems, such as handicapped children and children in federally impacted areas.

(4) That coordinating machinery be established to provide a means of exchange of information and experience regarding State programs of education of migrant children.

(5) That State committees on migratory labor make a study of the State laws to determine actual provisions, both permissive and restrictive, for the education of children of nonresident status.

(6) That State and local school agencies enforce attendance at regular schools and that summer schools be established to continue the education of migrant children.

(7) That school and community facilities be available for migrant children and youth as well as to other children and youth of the community.

(8) That a minimum age be established in Federal legislation for the employment of children in agriculture outside school hours and that special attention be given to the number of hours and conditions of employment under which children and youth are employed in agriculture.

Thank you.

Mr. ELLIOTT. Thank you very much, Miss Gilbert, for your testimony.

If there are no questions, our next witness will be Mr. Irving M. Selis, executive director of the Associated Blind, Inc.

STATEMENT OF IRVING M. SELIS, EXECUTIVE DIRECTOR, THE ASSOCIATED BLIND, INC.

Mr. SELIS. Mr. Elliott, I have a copy of my statement, as well as other matters which I wish to include in the record.

Mr. ELLIOTT. Without objection, the statement of Mr. Selis will be received for the record of the subcommittee at a point immediately following his oral presentation.

Mr. SELIS. I will give it to the reporter, Mr. Chairman.

Mr. Chairman and gentlemen, I wish to submit for the record several documents which I feel have a direct bearing on the subjects under consideration by your committee. These include statements by Anthony Musillo, 34 Monroe Street, New York City, and Beatrice Lindemann, 22 East 11th Street, New York City; a paper by Mr. Barney Mamet, secretary of the Associated Blind, entitled "Publicity About the Blind, Sense and Nonsense," and a paper which I presented to the American Association of Workers for the Blind at its last annual convention in July.

My paper, entitled "What Hope for the Blind in Tomorrow's Economic Planning," is the result of 40 replies to a questionnaire mailed to all directors of vocational rehabilitation service programs for the blind throughout the United States and possessions. In this paper, as well as in the additional material which I am submitting for the record, you will find a number of recommendations which, I trust, will prove helpful in your deliberations.

Programs for the training of the blind, without reasonable assurance for remunerative employment, are meaningless, wasteful, and costly, as well as most discouraging and frustrating to the rehabilitant. Frequently, an individual is encouraged to go through several types of training because of failure or inability to find appropriate employment. It is quite apparent to all familiar with this situation of procrastination that an extremely intensive program of public education must be formulated to enlist community resources, including local, State, and Federal Governments, to remove the retrogressive attitudes attached to the stigma of blindness, and thereby provide wider opportunities for employment of the qualified trainee.

Another practical solution to this difficult problem would be the expansion of the principle underlying the vending stand program to other avenues of preferential employment for the blind by the Federal Government. Does it not seem needless, costly, and pointless to have qualified blind people upon completing a period of training remain idle or be shuttled back into sheltered workshops?

With regard to pending legislation dealing with independent living, we should differentiate between the philosophy of social service and vocational rehabilitation services. Independent living programs deal with services of self-care, medical help, homemaking, sheltered employment, and homebound occupational therapy. Vocational rehabilitation services should be confined to the responsibility of adjustment and training toward the objective of remunerative employment.

Services toward independent living should remain the responsibility of voluntary and public welfare agencies, since such agencies have always assumed and carried this responsibility. The widespread belief is that the vocational rehabilitation service is charged with the responsibility of providing adjustment and training toward remunerative employment.

Is it possible that the proponents of the legislation to include independent living under the jurisdiction of the vocational rehabilitation service have concluded that the program for adjustment and training toward remunerative employment has attained its goal and that the vocational rehabilitation service is now ready to undertake the program for independent living?

The record to date does not support this conclusion so far as the great majority of blind people are concerned.

Thank you.

Mr. ELLIOTT. Thank you very much.

(Mr. Selis' material follows:)

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With regard to pending legislation dealing with "independent living," we should differentiate between the philosophy of social service and vocational rehabilitation. "Independent living" programs deal with services of self-care, medical help, homemaking, sheltered employment, and homebound occupational therapy, while vocational rehabilitation services should be confined to the responsibilities of adjustment and training toward the objective of remunerative employment. Services toward "independent living" should remain the responsibility of voluntary and public welfare agencies since such agencies have always assumed and carried this responsibility.

The widespread belief is that the vocational rehabilitation service is charged with the responsibility of providing adjustment and training toward remunerative employment. Is it possible that the proponents of the legislation to include "independent living" under the jurisdiction of the vocational rehabilitation service have concluded that the program for adjustment and training toward remunerative employment has attained its goal and that the vocational rehabilitation service is now ready to undertake the program for "independent living?" The record to date does not support this conclusion so far as the great majority of blind people are concerned.

PERSONAL EXPERIENCES AND COMMENTARY REGARDING THE NEW YORK STATE COMMISSION FOR THE BLIND, VOCATIONAL REHABILITATION SERVICE

(By Mr. Anthony Mussillo)

I feel that there is strong evidence to indicate that there is wastage and misuse of funds on the part of the vocational-rehabilitation service (commission for the blind). I believe that this organization's performance shows clearly that they are not achieving many of the goals toward which substantial sums of money have been appropriated. I base this opinion upon my own factual personal experiences with vocational rehabilitation and upon similar experiences of other blind individuals with whom I have spoken regarding this. Consider if you will the following sequence of events, and I am certain you will agree that our opinion concerning this organization is totally justified.

Late in the year 1958, I decided, with encouragement from the Associated Blind, an organization truly devoted to the interests of blind people, to attempt to obtain a position in the social-investigator field with the Department of Welfare of the city of New York. Our hope was to obtain a position for me in any one of the number of branches of the social-investigator category, i.e., old age home caseloads, blind assistance caseloads, intake, etc. My own feeling, which was

thoroughly shared by the Associated Blind, was that I was well qualified and capable of handling several of these positions.

The head counselor at VRS was informed that I was interested in taking the civil service examination for social investigator and asked what my prospects were of obtaining employment in this field. I specifically asked this question of him since I had known that a good number of blind people had taken this examination in the past and had not obtained the position. I certainly did not wish to waste my time or his time in seeking a position for which I could not possibly be certified on the part of the VRS. He told me to "take the examination and then we will discuss it." I could elicit no further statement from him at that time, although I made every attempt to do so. I naturally proceeded to take the examination.

I was shortly thereafter notified by the Civil Service Commission of the city of New York that I had passed the examination with a grade of 89 and that I would need a certification that I could do this work from the vocational rehabilitation service. I made an appointment with the head counselor of the vocational rehabilitation service, an appointment which he was reluctant to give within the immediate future without my emphasizing its importance to me.

Our discussion began with words to the effect, "Mr. Mussillo, prove to me that you can do the job and I will consider certifying you." I told him that I was a Spanish major in college; that I could both read and write Braille rapidly; that I was a speed typist, having had 8 years experience in transcribing; that I was able to travel with a guide dog or a cane, as the situation might warrant; that the grade I had obtained should indicate to some degree that I was aware of what the position entailed, and that having worked with the department of welfare, typing the work of social investigators for 8 years, grossly added to my knowledge of the functions of this position. I explained that I could do interviewing and interpreting of Spanish in the intake sections of the department of welfare, that an old-age home caseload, I felt, was a strong possibility for a blind person to handle, perhaps a blind assistance caseload or any other related work to this field. I emphasized that I mentioned these positions specifically as outstanding opportunities as they were the self-same positions being held and capably discharged by qualified blind in other States. I showed him a highly complicated intake form which I had obtained from the department of welfare, and which I could fill out myself on the typewriter by a system of tabulations.

The head counselor told me that he could not certify me to do this work. He said that I would have to go out to investigate these positions I was citing; to ask questions of the supervisors in the various sections of my welfare center where I was employed, and find out if they thought I could do this work. If they did, and someone "high up in the department of welfare would give me a letter stating they felt I could handle a particular position," then he would certify me. I stated rather cynically here that perhaps he would want me to obtain a letter from the commissioner of welfare, stating I was qualified and capable of handling a particular position. He responded that if I obtained such a letter, he would certify me immediately and without question. I stressed to him again that other blind persons were handling the same positions in other States. The vague response was that this was New York State and not another State. We went over and over the same ground, but the ultimate result was that I could not obtain a certification of fitness from the VRS. He again repeated that unless I obtained a letter from someone high up in the department of welfare stating that I could discharge the duties of a particular position, he could not certify me. I was told by the head counselor at the end of our interview not to make any further personal appointments with him, but if I had something on my mind, to write him a letter.

I would like to quote here from section 25B of the civil service law, section 3, which was the applicable law at the time:

"Upon request of an applicant or an eligible for a civil-service position who has been found to be blind, the New York State Department of Social Welfare, Commission for the Blind, shall obtain from such State civil-service department or municipal commission a detailed description of all duties entailed by such position, and shall investigate the extent of the alleged disability by examination of such applicant * * *."

Was it not then crystally clear that when the senior counselor asked me to investigate the duties of the sought-for position, in actuality, he was asking me to do his job? Wasn't it evident that very little if anything had been done in the way of researching these positions when other blind persons had ap-

plied for them to the vocational rehabilitation service in the past? The position of social investigator by the time I arrived upon the scene should have been known thoroughly in every detail and in all its ramifications. Surely, even if the vocational rehabilitation service had done just a small amount of investigation when each blind applicant had applied for this position in the past, they would have amassed a great deal of material concerning the capability of the blind for handling such work. They should without any doubt whatever, be able at this point to encourage or discourage any blind individual as regards this position even before they are close to taking the examination for such category.

Most importantly, isn't it obvious and rather shameful that the vocational rehabilitation service does not feel it really has the authority or power to certify a blind person for a particular position? Such is indeed the case for the senior counselor of the vocational rehabilitation service claimed that he would gladly certify if I could obtain a letter from someone "high up" in the department of welfare. He would certify me immediately, he claimed, if he had a letter from the commissioner of welfare, and, too, he requested that I get a statement from some supervisor in the department of welfare stating that they felt I could handle specific work in their unit. In effect, this man was strongly indicating to me that he felt he was powerless to certify me or any other blind person for such a position before someone else gave him the authority to do so. In other words, I was asked by the city of New York to obtain certification through him and he in turn was asking me to obtain certification from the city of New York. This is indeed a sad game to play with the professional futures of qualified blind. Doesn't it seem just from a very cursory inspection that these counselors are really asking their salaries for acting as glorified clerks? If they do not wish to get out into the field and investigate the details surrounding specific positions, to help create new positions, to present the blind as capable, rational-minded adults, and to pursue the interests of the blind in every way they know how, then it is better that clerks be hired for the vocational rehabilitation service at much lower salaries.

It is almost slanderous on the part of the head counselor to request no further personal interviews with a client but rather that communication take place by mail. There would be no reason for a counselor to shun a discussion with a blind client seeking a position. A letter can be thrown into a file or into a basket.

As all these factors made a strong impression upon me at the time, I wrote the senior supervisor of vocational rehabilitation service in Albany expressing to him completely in a detailed accounting just exactly how I felt on this matter. Through this letter and aided by the Associated Blind, we obtained an interview in the offices of the vocational rehabilitation service here in New York City.

Representatives of the Associated Blind and I expressed ourselves concisely and emphatically on this subject at the meeting. When I indicated to the senior supervisor of vocational rehabilitation that I was being refused certification for a position that was being adequately discharged by blind in other States, his response was "Well, perhaps we are a little slower in New York; that could be it." We received vague and inadequate responses to most of our queries and the ultimate result of this meeting was that vocational rehabilitation would see what it could do for me.

Ultimately, vocational rehabilitation service did for me what it has done for all the other blind individuals applying for this position which I think the records will show, isn't a great deal. I am wondering at this point what will happen to the next blind person who contacts vocational rehabilitation service for advice as to whether they should take the social investigator examination. What will it take to get this organization to finally admit that they are unable to cope with the situation?

Here is indeed a case of wasteful use of government funds. Not only are salaries being paid to counselors at the vocational rehabilitation service who are not performing the functions of their jobs adequately, but the goals for which the government funds are being appropriated are not being at all realized. Then too, the vocational rehabilitation service has spent a good deal of money to help blind people through college and through training courses. If all we can expect after going through college or specific training for employment is the menial task of transcribing typist, or work in a sheltered shop of one of the organizations for the blind, then these moneys are not serving the proper purpose. It has come to pass with most of the blind who are put through college on vocation rehabilitation service funds that the college education becomes the

end itself and not a means to an end. Going through college for a blind person is not a desire on his part to fill the 4 years between high-school graduation and unemployment, nor is it a desire to act as a bridge from high school to a dictaphone machine or work in a sheltered shop.

The blind who attend colleges and training courses spend many, many hours and much effort in learning various skills. Their aspirations are for someday to hold dignified positions; positions that will provide adequate incomes for their families; they want just as strongly as does any member of society to live as first-class citizens and decent human beings. If we are forced by the existing laws to turn to the vocational rehabilitation service for certification to perform a certain job, then it is essential for the dignity and very livelihood of the blind that vocational rehabilitation service be capable, be influential, fulfill its duties and obligations to the blind thoroughly and courteously and to realize above all when they should or should not encourage a blind person in his pursuits. If the vocational rehabilitation service continues to take the same attitude as they have in the past, which is quite comparative to the attitude of many private employers as regards the capabilities of blind individuals, then the sightless of New York are burdened with the organization that was really meant by the government to do so much for them.

It is imperative to remember that the blind of New York did not give vocational rehabilitation service the privilege or authority of having to certify them for desired employment. This power was given to them by law. We, unlike sighted people, have to have someone else judge our capability of performing certain duties. Someone else must judge us and their judgment is final. I discussed this law, then section 25B, with an attorney, and I was informed that he believed the Supreme Court would certainly declare it unconstitutional. He told me that it was a most flagrant violation of a citizen's rights. His contention was that if it came to pass that madmen controlled the vocational rehabilitation service, the law still would give them sole authority to certify upon the capability of blind individuals to hold certain employment.

It is conceivable that vocational rehabilitation service may need a separate division to handle the problem of professional employment. It is conceivable that they require a whole reevaluation and revamping of their methods and personnel. It is certain that steps must be taken to correct the unfortunate injustices and wasteful economic practices that have been taking place for so long.

Finally, I would like to point out here that I believe the individual blind person's opinions and factual experiences are much more weighty and meaningful as regards vocational rehabilitation service than would be some organizations for the blind in their attitude. Their opinions are violently prejudiced in favor of the vocational rehabilitation service because of the fact that they receive large sums of money in the form of training sums for the blind they supposedly set on the path to economic security. They cannot be expected to disagree with practices in which they themselves indulge. Let us only hope that somehow society will grow to learn what they really accomplish.

NEW YORK, N.Y., October 26, 1959.

MISS SARAH NEUFELD,
Associated Blind, New York, N.Y.

DEAR MISS NEUFELD: In connection with my recent experience with the Vocational Rehabilitation Service of the New York State Commission for the Blind, I wish to state that the contents of this letter is in no wise a criticism, but rather an attempt to indicate how the service can be of greater help to the blind.

As you know, I have had 35 years of business experience, 25 of which were in an executive capacity with one company. My former employers were men of stature and achievement, among them the late Fiorello H. LaGuardia. I mention this only to indicate the scope of my experience.

It would seem to me that were there some way devised so that all blind people needing rehabilitation were not segregated like second class citizens and given more individualized attention, the program would be greatly improved. In other words, I saw people from all walks of life, of all capabilities and potentials, lumped together without too much regard for background or future potential. Despite the fact that I have lost my eyesight, I am sure that my intelligence has been in no way altered nor has the experience I have gained in any way

been diminished. I held a position as assistant to arbitrators; I have the ability to talk to people and smooth ruffled feathers; I have a knack of bringing together persons diametrically opposed and reaching a meeting ground. Therefore, for me to become a transcription typist seems rather a waste of talent. I started out 35 years ago as a typist; the loss of my sight now seems to turn the calendar back that many years.

Rehabilitation, in my opinion, should have a large staff of qualified persons in the personnel field; people who know how to place people and then sell these qualified people to employers. Also, a great deal can and should be done to educate the public and employers.

Rehabilitation is fine, but I don't think in its present state it goes far enough.

If the contents of this letter is of any value, you may have my permission to use it.

Sincerely yours,

BEATRICE LINDEMANN.

PUBLICITY ABOUT THE BLIND—SENSE AND NONSENSE

(By Barney Mamet, secretary, the Associated Blind, Inc.)

(Presented at the 44th annual conference of the New York State Federation of Workers for the Blind in New York City, September 18, 1958)

It is with some apprehension and misgiving that I approach and explore the subject: "Publicity About the Blind—Sense and Nonsense." In a paper of this length, justice cannot possibly be done to the vast scope and complexity of this multifaceted subject encompassed in the all-inclusive term "publicity," which is closely identified with its twin sister professions of fund raising and public relations. Especially is this true in our day and age of strong pressure groups with each jockeying for popular approval and special legislation; of the various-media of farflung communication and rapid transportation with the power as never before known in history for disseminating information to every part of our world; and of large scale promotional campaigns which run the gamut of human emotions to make the contributors' tears flow fast and their dollars even faster.

This subject becomes further complicated when we enter into the area of what should constitute the criteria for proper ethics and practical standards intended to help crystallize most effectively the noble motives and avowed purposes of numerous and diverse philanthropic organizations which of necessity must perpetually rely upon the financial support and sympathetic interest of the general public in order to survive and carry on.

While publicity is the lifeblood of philanthropy just as advertising is to commerce and industry, charitable organizations, unlike big business, must take into account the added factors of social responsibility to those they serve as well as the faithful discharge of their stewardship with which they have been entrusted by public-spirited citizens, or, if you will, by their contributors whose goodwill and generosity must be courted, counted upon, and continually cultivated to keep pace with the increasing demands of blind people for expanding services.

For these and other reasons to follow, I am quite aware of the formidable task I have embarked upon and of the hazardous course to be navigated between Scylla and Charybdis—between those who are professionally engaged in the field of publicity and who generally assume the position that the means in whatever manner, shape or form the exigencies of any given situation may call for justifies the end; and those comprising a large segment of the blind who are unalterably opposed to any type of publicity which would tend in the slightest degree to compromise their idealistic goal for equal status in the sighted community without due regard for the realistic means required to bring about this ultimate end.

The professionals know only they have a job to perform; namely, to ascertain the most immediate and effective way to publicize an individual, event or certain phases of work for the blind to attract public support and the largest amount of money possible for the particular organization employing their services. With this sole purpose in mind, fund raisers and directors of public relations are not above using expediency, distortion of ideas and facts, highly incredible situations, fantastic and exaggerated portrayal of the blind person's accomplishments, words and phrases of misleading symbolism, the overwhelming dramatic impact

of the so-called "human interest" stories; the heartrending and stirring appeal to human emotions and subconscious prejudices and many other devious devices calculated to evoke the desired public response. In their zeal they lightly shrug off the actual truth and real facts if such should prove an obstacle to their assignments. More often than not they perpetuate and care less about dispelling the existing prejudices, traditional attitudes, and stereotyped images that the public has about the blind person pictured as helpless, dependent, and inept. It is regrettable that these publicists who wield tremendous power and can be such a significant force for good have little or no knowledge of the historical struggle of blind people to shake off the shackles of their handicap with its concomitants of pity, ineptness, condescension, discrimination, invalidism, beggary, and wardship. Their ignorance of such matters is appalling and their indifference to any attempts to alter their practices and channel their efforts into more enlightened directions is, to say the least, exasperating to blind people desiring and working for social equality and economic independence in the sighted world. They merely smile indulgently at such efforts as though to imply "I know my business and you know yours but don't let one interfere with the other."

However, the overwhelming majority of blind people and many of the blind workers within and outside of organizations for the blind are very resentful of much of the publicity material foisted upon the gullible public. They feel that progress in work for the blind would have been much further advanced were the professionals required to possess greater integrity and knowledge of and expected to work more closely with their respective organizations in work for the blind. Blind people feel that their dignity, self-respect, and aspirations ought never to be sacrificed or even compromised for the sake of "publicity" particularly when doing so characterizes and retains the worst features of the past. They too must face the undeniable fact that the stereotyped prejudices, traditional attitudes, and misconceptions encountered in everyday life are deeply rooted in humanity and have come down to us from antiquity itself. The psychological implications and social ramifications of the handicap of blindness appear in so many subtle and disguised forms and vary so widely from one part of the world to another, indeed from community to community, that it is well nigh difficult to eradicate or even reduce to any appreciable degree as rapidly as one would wish the gulf that still exists between the blind and the seeing despite the advanced media and increased knowledge at our disposal. In short, the blind disposed to intellectual honesty and objectivity cannot themselves all agree as to what would be the most realistic and practical manner to realize complete social adjustment and acceptance totally free of any conscious or subconscious feeling that somehow "differences" do still exist.

In his book "Adjustment to Physical Handicap and Illness," published by the Social Science Research Council in 1947 and revised in 1953, Barker points up several interesting facts to explain these seeming inconsistencies among the blind and workers for the blind. He states that: "No group among the physically handicapped in the United States has been so favored by special legislation as the 'legally blind.'" Further on he says: "No other groups concerned with the disabled appear to be as well organized and as well financed as the associations for the blind."

In the same book, however, Barker makes the keen observation that: "Few disabilities have been the object of such early and lasting concern as loss of vision." And in dealing with the social significance of blindness, Barker also observes: "There is general agreement that the severely impaired vision is a misfortune, and in only a few scattered instances have any advantages been claimed for blindness." The history of the blind leaves no doubt of the truth of these observations.

It is of paramount importance to bring all our knowledge and resources to bear upon the problems concerning us today. During the last 20 years or so, much greater progress of a fundamentally sound and realistic nature has been made than ever before in the history and development of work for the blind. Through the efforts of agencies for the blind and that of the organized blind themselves, it is becoming evident, more and more, that public education offers the best key to the field of public relations—of bringing genuine understanding and keen insight and analysis into the attitudes which the seeing and the blind feel toward each other. By eliminating all of the nonsense and misinformation so prevalent in much of the publicity, and which causes confused thinking among the seeing and disillusionment among the blind, and by making sure that only such publicity that will reflect sense and truth in convincing and unadulterated presenta-

tion can we hope to cut through an apparently hopeless problem. To make a suitable beginning, both extreme positions must be avoided with due respect for each other's point of view and experience. It is incumbent upon all of us to resist the timeworn temptation to exploit the motif of polarity in publicity. It does not make for enlightenment or understanding and serves no worthwhile purpose to picture blind people either as "geniuses" or as "pitiable beggars"; to place them on pedestals endowed with extraordinary virtues or have them grovelling in utter abjection; in surrounding them with a halo of flawless admiration or brooding in hopeless resignation; performing incredible feats of ambitious enterprise or living in pathetic helplessness.

In connection with the age-old tendency of seeing people to think of the blind in extreme opposites, it is interesting to note that in separate studies made by Patterson and Langworthy over 25 years ago, they found that over 300 books contained a blind character. Both arrived at a similar conclusion that these books portrayed the idealized and abnormally good blind person exemplified by Bertha in Dickens' "Cricket on the Hearth" as contrasted with Pew in Stevenson's "Treasure Island" as the repugnant and abnormally bad blind person. These investigators also pointed out that the clever and capable blind man is found in fiction occasionally and that the normal well-adjusted blind man is rarely found in fiction. This practice is still carried on in the press, radio, and television. Blind people who have acquired a very high degree of adjustment and proficiency in conducting their lives to the satisfaction of those about them are not usually considered newsworthy. The fact that quite a number of blind people have learned to master and participate with considerable ease in those events and activities that are commonplace in the workaday world does not lend itself to "good publicity." Obviously, in such an atmosphere permeated with such inconsistency, cross-purposes and misplaced emphasis on the proper values, something undoubtedly is fundamentally wrong and unsound.

Not many months ago one of the best known agencies in Greater New York presented a TV broadcast of its overall program concerning its work on behalf of the thousands of blind people it claims to serve. The well-known commentator and interviewer asked several questions which were echoes out of the dark medieval past. Such questions as "Would you rather be dead than blind?"; "Do you have any fun?"; and "Have you ever known blind people who have committed suicide?" were deeply resented and deplored by blind people. The implications of these questions could only have left a most negative impression upon the viewers and listeners.

Then about a year ago a series of tape recordings for radio broadcasting was submitted throughout the country by one of our national organizations which purports to advance the cause of the blind in every way possible. Nevertheless, these tapes were replete with words and phrases which were misleading in their symbolism and connotation. Expressions as "in the valley of the shadow," "buoyant spirits," "milk of human kindness," "joyful noises," and the like only accentuate rather than diminish the proverbial gloom and darkness in which the blind are supposed to dwell.

And then there was a story of the successful blind insurance agent. It said that he was not known to be blind to his clients at their first meeting because of his exceedingly normal manner and behavior. The story went on to say that whenever it became necessary for him to look up rate schedules he would do so by putting his hands into his briefcase to read the braille notes without exposing them. Since this blind man was supposed to have been successful, why was it necessary for publicity to utilize the angle of an uncanny and abnormal type of behavior?

However, one cannot help but wonder how much publicity has really done for the braille system. For recently, over one of our national radio networks a most prominent and liberal news commentator was interviewing a gentleman from one of the Asiatic countries. He was describing the poor conditions of his people and their widespread illiteracy. At this point the commentator remarked that "a man who cannot read is like a blind man." Certainly such sweeping generalizations leave the erroneous impression that the blind man is inferior, helpless, and lacking in ability and learning.

Several years ago quite a furor arose mong the blind and workers for the blind when in a certain moving picture the actor who played the role of a blind man felt with his fingers the facial features of his sweetheart and was thereby able to describe how beautiful his girl was. This scene stirred and captivated the seeing audience not realizing how the movie moguls played upon their credulity

and emotional sympathy because they wanted to believe that blindness had its compensations by giving the sightless person supersensitive fingers and miraculous power not to mention, of course, the heroine's faithful love to the man who had become blind.

Such instances can be multiplied ad infinitum. As stated at the outset, it would be impossible to cover the many facets involved in publicity. However, I believe that the paramount issues and broad aspects of this subject have been touched upon sufficiently to indicate areas which call for serious consideration and reappraisal of that kind of publicity which will emphasize reality and avoid the extremes; to infuse sense into our publicity and eliminate therefrom the nonsense which has prevented a realistic appreciation of the blind person by the public.

WHAT HOPE FOR THE BLIND IN TOMORROW'S ECONOMIC PLANNING?

By Irving H. Selis, Executive Director, The Associated Blind, Inc.

(Presented at the 33d annual convention of the American Association of Workers for the Blind in Detroit, Michigan, July 8, 1959)

Among the numerous problems which have remained the most difficult and baffling in the area of work for the blind is that of creating or finding opportunities for their adjustment and ready acceptance into the economic structure of society. Hence, about 2 months ago, when I was asked to prepare a paper for this convention dealing with the "Economic Picture 1959 In Relation to Services and Resources," I was reluctant to undertake at such short notice this formidable task. But the sober realization of the importance of this subject impelled me to make a beginning with the hope that from this spadework there would develop a concerted and realistic effort by all of us in the American Association of Workers for the Blind to reevaluate the rehabilitation and employment programs for tomorrow's economic planning for the blind.

Since the training, rehabilitation, and employment of blind people flow from the mainstream of the vocational rehabilitation service program, it is only natural to have centered our interest in this area. No one can question the tremendous impact which this program has brought into the lives of blind people for their rehabilitation and employment opportunities. However, after 15 years of operation it has been the feeling of professional and lay workers alike that in the light of certain glaring deficiencies that have developed, the program calls for review and analysis; thus the need for this survey.

In order to gather the data pertinent to this paper, which I feel can only be considered an outline for a broader study of this subject, I sought the aid of all directors of State vocational rehabilitation service programs for the blind. Realizing that time was limited, and mindful that their duties might not permit them to reply to a more lengthy and searching questionnaire, I confined it to 11 questions which I thought would be specific in nature and simple to answer. In addition to the 49 States, questionnaires were sent to the District of Columbia, the Virgin Islands, and Puerto Rico. Although the Virgin Islands and Alaska responded, they are being omitted from this study because their programs have only recently been instituted. Of the remaining 48 States, the District of Columbia, and Puerto Rico, 39 States and the District of Columbia, or 80 percent responded.

While it was felt that the completion of the questionnaire would merely involve established agency experience and consultation of records, some of the responses proved most unexpected and revealing. For example, in response to question 7, "Total caseload during last fiscal year," such replies were given as "Unknown"; "I do not have this information available"; and "This information was not provided by our counselors."

Question 1, "Name of agency director," was asked for the purpose of reference in the event that followup correspondence would be necessary. Evidently this question proved somewhat difficult in three instances as the name of the agency itself was given rather than that of the director.

Answers to questions 2 through 8 have been analyzed and tabulated statistically in a chart appended to this paper. The purpose of these questions was to ascertain the total caseload in the last fiscal year, the number of counselors and number of placement officers, and their classification as to "blind," "with useful vision," and "sighted"; and classification of agency director as to "blind," "with useful vision," or "sighted."

The chart is composed of seven columns, divided into five groupings. The columns are headed as follows: "State" (indicated by number, starting with State having highest prevalence of blindness¹); "Caseload in relation to estimated prevalence of blindness"; "Placement in relation to caseload"; "Average caseload per counselor"; "Average placement per placement officer or counselor"; "Counselors and placement officers," "Blind," "With useful vision," "Sighted"; and "Director," "Blind," "Useful vision," "Sighted." Group A includes States having a prevalence of blindness of 20,000 and over; group B, 10,000 to 20,000; group C, 5,000 to 10,000; group D, 2,000 to 5,000; and group E, under 2,000.

A careful scrutiny of the chart brings to light a number of interesting factors. However, time will permit a discussion of only three of them.

In comparing State B-4 with State A-1, certain important differences are to be noted. State B-4 has a prevalence of blindness of 11,000, a caseload of 1,500 and 270 placements as against State A-1 with a prevalence of 28,000, a caseload of 900, and 209 placements. These figures raise several questions. When we realize that State A-1 is the wealthiest State, the most highly industrialized and diversified, and exceeds the prevalence of State B-4, which is semiagricultural in character, by almost two and one-half times, the question arises as to whether State A-1 is understaffed in its vocation rehabilitation service program or whether State B-4 is doing a much more effective job.

Furthermore, State A-1 has 11 counselors, all of them sighted, while State B-4 has 8 counselors, 5 blind, 1 with useful vision, and 2 sighted. Is it possible that State A-1, in order to maintain a record equal to that of State B-4 both in caseload and placement, should increase its staff proportionately and include blind counselors and placement officers? Does it not seem altogether fitting in a program designed to find employment for blind people and to demonstrate to the public the capabilities of the blind themselves that vocational rehabilitation service agencies should be the first to set the example? These two States were selected for comparison to point up the inescapable observation that blind people can be employed as counselors and placement officers and can perform their jobs with creditable results.

Comparing State A-2 with State A-3, where the prevalence of blindness is approximately the same and where both agencies employ blind counselors predominantly, namely, 10 out of 18 for the former and 14 out of 16 for the latter, it is to be noted that for the last fiscal year State A-2 showed 264 placements out of a caseload of 455 (58 percent) as against 197 placements out of a caseload of 1066 (18.4 percent) for State A-3. There is a most striking difference in placement of 40 percent between these two States. One cannot help but wonder about the market difference in the record of achievement for State A-2 when State A-3 has in excess of 2 million population, is much more highly industrialized and its history and experience in work for the blind are much older and more extensive.

To further illustrate the need for a more comprehensive study of the overall vocational rehabilitation service program is again borne out by the comparison between State C-10 and State C-4. The difference in the prevalence of blindness between these two States, located in the same geographical area, is approximately 2,000 more for State C-4. Comparative figures for these two States show that the staff of C-10, consisting of 1 blind and 10 sighted counselors, carried a caseload of 882 and placed 169, while State C-4 with 2 blind, 2 with useful vision, and 34 sighted counselors, carried a caseload of 600 and placed 63.

The comparison between these two programs is of especial interest since State C-4 is a multiple agency in which service to the blind is integrated with all other physically handicapped groups, and State C-10 is a single agency serving the blind only. Here again we are confronted with the long debated issue as to whether the needs and interests of the blind are not sidetracked and lost when grouped with other physically handicapped rather than being served as a single unit. This observation seems to be similarly true in other States maintaining a multiple agency program.

With regard to question 9, "Number of legally blind people in the State now employed * * *" in five major categories, "blind" and "with useful vision," it is gratifying to note that 17 States do maintain such records in one form or another. It would seem desirable that all States maintain such records so that periodically employment figures could be gathered as a yardstick to measure the

¹ American Foundation for the Blind, "Estimated Prevalence of Blindness as of June 30, 1958."

progress for total employment of the blind as well as for various types of employment. Such a complete record would serve as a helpful guide toward determining what types of employment over a period of time would prove most suitable for the blind and the visually handicapped to enter from the viewpoint of equal competition, permanency, and compensation. The replies to this question were not tabulated because they did not furnish a broad enough base from which any definite conclusion could be derived. However, it should be mentioned that in the interest of fair and just legislation to the totally blind, and to clear up the existing confusion in the mind of the public as to the wide variation in degree between the totally blind and those with visual acuity of 20/200, serious thought should be directed to this area of our work.

A further examination reveals that a considerable number of housewives and homemakers were included in the figures given as placements. Since the term "placement" is interpreted as remunerative employment, and while no one will deny that the little woman's work is never done, is the housewife or homemaker to be considered a placement? One State included 43 such placements in its total figure. Is it possible that in some States the program has reached the bottom of the barrel? Though no one can dispute the value of giving training and rehabilitation to housewives and homemakers toward social adjustment and independent living, it is difficult to reconcile these accomplishments in the light of employment.

Another unusual matter that comes to our attention concerns the "Number of blind persons rehabilitated, by job or occupation at closure, fiscal year ended June 30, 1957," found in "Rehabilitation Service Series No. 450, Supplement 7," issued by the Department of Health, Education, and Welfare. Included in this list are to be found such jobs and occupations as "accountants and auditors," "trained nurses," "draftsmen," "bookkeepers and cashiers, except bank," "waiters and waitresses, except private family," "sheriffs and bailiffs," "brick and stone masons and tile setters," "firemen, other than process firemen," and "chauffeurs and drivers of motor vehicles." While this report informs us that these people were blind when accepted for service, it would appear that their sight was restored in order for them to hold down such positions.

It is most commendable for the vocational rehabilitation service to render eye restoration service, but would it not be in the interest of accurate recording to list such achievements under the category of "sight restoration" rather than employment under blindness? In the first place their employment is not obtained as blind people but as people who can see. Secondly, it is not fair to the blind to constantly have to combat the false impression that prevails in the mind of the public that they are "geniuses" and perform unbelievable feats. If the doors of opportunity for the blind in tomorrow's economic planning are to be swung wide open, one of the necessary steps to be taken is to gear our publicity so as to avoid exaggeration on the one hand and false sentiment on the other.

The following is quoted from an article that appeared in the press within the past month:

"One of the first basic things that (name of agency) teaches is posture and stance to avoid accidents. When 'Mary' lights a gas oven she does not lean over as do most housewives. Should she lose her balance there might be an accident. Instead she gets down on her knees. Housewives with normal sight might learn from 'Mary' a number of safety techniques for the tasks of homemaking."

In order for a blind person to be trained and rehabilitated to assume a normal place in society, it is necessary to depict a blind person doing the "abnormal" thing to prove that he is normal?

On the one hand the vocational rehabilitation service disseminates publicity to the effect that a blind person has been prepared to go out and do a day's work and take his rightful place in society as a normal human being. On the other hand, the private agency for the blind is unashamed to resort to any type of publicity which will play upon the sympathy of the public for the purposes of raising funds. (A treatment of this subject has been covered in a paper entitled "Publicity About the Blind—Sense and Nonsense," by Barney Mamet, secretary of the Associated Blind. This paper is available upon request.)

With reference to question 10, "Describe the training facilities used in your program such as private agencies for the blind, other community facilities, etc.," most of the replies indicate the use of private agencies, schools, colleges, trade schools, etc. However, there is a strong emphasis on the need for more practical training facilities and on-the-job training.

With regard to question 11, "In your opinion what type of program should be instituted for improving employment opportunities for the blind on local, State, and National levels?" 11 States did not answer. One State indicated its satisfaction with the program as it now exists. Of the remainder, it was the consensus of opinion that much more emphasis and planning should be devoted to public education with particular stress upon obtaining the cooperation of private industry and greater governmental participation through programs of appropriate legislation and implementation. Some felt that the President's Committee on Employment of the Physically Handicapped should also be extended to State and local levels with Governors' and mayors' committees.

The following are a few excerpts from the replies of several State directors in answer to this question:

1. "Extensive adjustment training such as travel training, manual dexterity, etc."

2. "More emphasis on training, better supervised training, and much more sincere effort on the part of the agency for placement."

3. "Staff workers who will get out and do the job; all talk and no pay makes client dubious of service programs. Staff must be trained and function after training."

4. "A good employment program for the blind cannot be developed unless the workers in agencies doing work for the blind really believe what they say when they talk about the fact that the blind are employable. The most important single qualification of a worker in a program for the blind should be his belief that the average blind person can do the average job in the average office or factory if he gets training and opportunity. If the workers really believe this (emotionally as well as intellectually), if they are not simply giving lipservice to the idea, the rest will tend to follow naturally."

5. " * * * An expansion of public interpretation activities at all levels would be productive of more work opportunities for blind persons. It would also assist in the effort to let all blind persons know about the service programs available."

6. "A long-term educational program alerting employers to the skills trained blind workers can develop. This program should be extensive in scope, and extensive in nature, and carried out by skilled public information specialist."

7. "More expert field consultants in the Federal Office of Vocational Rehabilitation who could visit the States. Have some organization (possibly the NRA office) serve as a clearinghouse for all questionnaires."

8. "(a) An effort on the national level aimed at opening up large industries to the blind whose policies are now opposed to the hiring of the blind.

"(b) A study of the effects of automation on the hiring of the blind and methods of obviating these effects."

In reviewing, analyzing, and evaluating the program of training and employment for our blind in tomorrow's economic planning, we must pursue a realistic course. Within the realm of public education we must enlist the cooperation of those employers now hiring blind people to constitute themselves into committees with a view of spreading the word to other employees within their industries as to the capabilities and satisfactory work records of the blind people they themselves employ.

As another effective weapon in this crusade, a progress report of the vocational rehabilitation service program should be mailed periodically to prospective employers, noting the areas of employment which the blind have filled with creditable success. This procedure could also serve as the door opener for placement officers.

Legislation should be enacted in which employers receiving Government contracts would be required to hire blind people after it has been established that certain operations can be performed by them.

As an incentive to employers to hire blind people, a provision for a tax reduction plan should be considered as another practical measure.

As an extension of the principle of the vending stand program, preferential status should be considered in the field of piano tuning and civil service opportunities where it can be demonstrated that blind people can qualify.

If the hopes of blind people are to be crystallized through our planning for tomorrow, such measures and recommendations as herein suggested must receive our serious and immediate consideration. Less procrastination and more determination will spell the difference between failure and success of what was meant to be a most effective and worthwhile program.

Study and analysis of vocational rehabilitation service program for the blind

State	Caseload in relation to estimated prevalence of blindness (percent)	Placement in relation to caseload (percent)	Average caseload per counselor	Average placement per placement officer or counselor	Counselors and placement officers			Director ¹
					Blind	With useful vision	Sighted	
Group A—Prevalence 20,000 and over								
1.....	3.4	22.4	84	19	-----	-----	11	S
2.....	2.1	58.0	25	33	3	7	8	B
3.....	5.1	18.4	67	12	7	7	2	UV
Group B—Prevalence 10,000 to 20,000								
1 ²	3.8	(³)	46	(³)	2	3	10	S
2.....	2.1	23.3	40	11	8	-----	1	S
3.....	(⁴)	(⁵)	(⁵)	(⁵)	10	7	3	S
4.....	13.4	17.8	189	90	5	1	2	S
Group C—Prevalence 5,000 to 10,000								
1.....	7.7	9.5	46	25	12	-----	8	S
2.....	4.9	17.6	97	17	2	1	2	B
3.....	(⁶)	(⁶)	(⁶)	34	6	4	8	S
4 ²	7.2	10.5	16	9	2	2	34	S
5.....	5.2	23.4	48	13	2	-----	7	S
6.....	2.5	30.4	35	11	5	1	-----	S
7.....	3.0	13.7	50	7	5	-----	-----	B
8.....	(⁷)	(⁷)	(⁷)	19	1	-----	8	S
9.....	2.1	(⁸)	40	(⁸)	1	1	2	S
10.....	13.6	19.1	80	15	1	-----	10	B
11 ²	4.3	20.3	8	2	2	-----	31	S
12.....	7.6	17.6	66	9	4	3	3	B
Group D—Prevalence 2,000 to 5,000								
1.....	4.2	13.0	40	5	2	1	2	B
2 ²	7.5	20.0	15	2	-----	-----	38	B
3.....	4.1	19.8	37	7	1	-----	4	S
4 ²	6.8	17.0	22	25	2	-----	45	S
5 ²	5.6	(⁹)	5	(⁹)	1	-----	40	S
6.....	10.4	12.5	65	7	2	-----	5	S
7.....	7.1	13.4	87	35	-----	1	2	B
8.....	4.5	22.1	40	9	2	2	-----	S
9.....	(¹⁰)	(¹⁰)	(¹⁰)	3	1	-----	2	S
10.....	5.4	25.0	72	18	-----	1	1	B
11.....	6.1	39.4	29	12	2	-----	3	S
12 ²	8.6	50.0	100	25	1	-----	1	S
Group E—Prevalence under 2,000								
1.....	5.2	3.3	27	35	1	-----	3	S
2.....	14.1	12.2	91	22	1	-----	1	S
3.....	7.3	21.6	22	6	2	-----	2	B
4.....	5.1	27.5	35	10	-----	2	-----	S
5.....	7.6	11.9	42	5	1	-----	1	B
6.....	(¹⁰)	(¹⁰)	(¹⁰)	10	-----	-----	1	S
7.....	5.0	29.5	61	18	1	-----	-----	B
8.....	(¹⁰)	(¹⁰)	(¹⁰)	9	-----	-----	1½	S
9.....	9.1	5.0	100	10	½	-----	-----	B

¹ B=Blind, UV=With useful vision, S=Sighted.² Multiple agency.³ No record.⁴ Unknown.⁵ Not tabulated.⁶ I do not have this information available.⁷ This information was not provided by our counselors⁸ Unable to break down.⁹ Our fiscal report does not include this information.¹⁰ Not given.

Mr. ELLIOTT. Our next witness will be Miss Sylvia Golden, of the League In Aid of Crippled Children.

Is Miss Golden here?

I will now recognize the gentleman from New York, Mr. Wainwright, who will present the next witness.

Mr. WAINWRIGHT. Mr. Chairman, it is a pleasure to present to the committee the representative of the New York State Mental Health Board and also the Mental Health Board of Suffolk County, a county of about 600,000 inhabitants outside of New York City.

Mrs. Huntington, would you come forward and give your testimony?

Incidentally, Mrs. Huntington is the wife of the New York State Assemblyman from the Second Assembly District in the State of New York.

Mr. ELLIOTT. We are happy to have you.

Mrs. HUNTINGTON. Thank you very much.

Mr. ELLIOTT. Mrs. Huntington, let me say that when you have finished, if you summarize your statement, the entire statement will go into the record.

You may proceed.

**STATEMENT OF MRS. PRESCOTT B. HUNTINGTON, SKILLS,
UNLIMITED, ST. JAMES, LONG ISLAND, N.Y.**

Mrs. HUNTINGTON. The needs in the field of mental health, financial and otherwise, are numerous and glaring. The progress made in the past 6 years in the treatment of the mentally ill has been the direct result of research and is an indication of future advancement yet to come.

I have selected four categories where I feel that encouragement from the Federal Government would further the findings of the past 6 years, producing results which could be felt throughout the Nation.

(1) Federal money is being used to help support nursing homes for the aged, homes for the blind, homes for handicapped children, and for the disabled. In the event that a patient in these homes is diagnosed as mentally ill, this Federal money is no longer available to them, and the patient then becomes a State responsibility and is removed to the State hospital.

If the illness is diagnosed as of a mild nature, it is entirely possible to care for these patients within the walls of the private institution, thus allowing them to remain in their present environment and in surroundings which are more suited to their needs than that of a State institution.

It is suggested that Federal funds be extended to include the care of patients with mild mental disorders within the confines of the private nursing home or institution.

(2) The Hill-Burton Act provides for the distribution of Federal funds for the construction of hospitals, nursing homes, public health centers, and diagnostic centers on a third of the cost basis. There is a great need for day centers for emotionally disturbed, handicapped and retarded children, where those with an IQ of 50 or less can be educated in terms of their own capacities, and where psychological services can be made available to them.

The worth of these centers has already been proven. There is a State operated one in Delaware, and I believe five or six more throughout the country. The place for these children is not within the walls of the public school, for their needs are so specialized and the training that they require so far removed from that of their normal brothers that it is imperative that they have a center quite apart from the local school.

The removal of the burden of these children from their homes for at least a few hours of the day will make for ease and easing of the tensions within those homes and for better regulation of the lives of their families.

The second change that I would suggest in the Hill-Burton Act is a provision for the construction on a third of the cost basis of halfway houses for patients released from State hospitals. It is common knowledge that a discharged patient from a mental institution is in need of assistance in returning to the community. It is also a fact that very often the family of the patient is often unable to give the proper help and encouragement to their relative, either through lack of understanding of the problem, through an inability to know how to cope with the patient, or because there is no one at home during the day.

A center that would be either a residential and/or a day center where released patients could be helped by trained social workers to return to industry, where they could be encouraged to stay in their jobs once the jobs had been acquired, and where the bereavement from the shelter of the mental institution could be lessened, would accelerate release from the institution and encourage the community to take responsibility for its own people.

There is a great lack of public support for the group of children who will never be able to participate in the normal life of the community, and for the recently released mental patient. I believe that an amendment to the Hill-Burton Act providing for the construction of day centers for children and halfway houses for released mental patients would encourage communities to visualize the needs for these services as well as make it feasible for them to embark on such projects.

(3) A rehabilitation program within the walls of a State hospital is a sorely needed program. To place within these institutions vocational counselors, trained to teach the skills required for industry, trained to raise the standards and talents of the individual, and trained in the art of family and marital counseling, would assist immeasurably in the recovery of the patient and in his return to society.

Teams embracing all of the disciplines made up of all of these trained persons who would maintain contact with men and women of the community to which the patient was returning, and who would work with the patients in applying all of their varied skills to the final release of the patient, would be of inestimable value. An appropriation from the Federal Government to be administered by the Department of Mental Hygiene, that would make teams of this description available to our mental institutions throughout the Nation, would shorten the length of time a patient had to spend in a hospital and terminate the financial responsibility of the State to the individual at an earlier date.

(4) Trained personnel in the field of social work is very scarce, and ways and means of inspiring young people to embrace this profession are very much needed. With the financing of schools of social work and the creation of scholarships to alleviate the financial burden of graduate studies, the shortage of trained counselors could be met and the field of rehabilitation in the area of mental health greatly enhanced.

These four channels for Federal appropriations would do much toward assisting those less fortunate to become useful members of society.

Mr. ELLIOTT. Would you tell us what your definition of a half-way house is?

Mrs. HUNTINGTON. It would be a shelter where released mental patients, people who are not thoroughly adjusted to return to the community, but who no longer needed the assistance of the hospital, itself, could either reside or use it as a day center while they are becoming readjusted to the community.

Often a mental patient who takes a job and seems to be securely established in that job finds after a week or 2 weeks that it is more than he can manage, and he has to get away. It takes time on the part of the social worker to urge that individual back into the job, and it often cannot happen. With an understanding employer, this can take place.

You can imagine the therapeutic advantages from such an experience. That is only one of the many ramifications. The outstanding halfway house, I think, is Fountain House, in New York, which is doing a wonderful job along these lines, with the help and cooperation of employers in the neighborhood, with a trained staff of workers to assist these people.

Mr. ELLIOTT. Thank you very much, Mrs. Huntington.

Our next witness is Miss Sylvia Golden.

Is Mr. Horace Mann, director, College for Teachers, present?

Mr. Bernard Frankel, executive director, Long Island Consultation Center?

Is Mr. Thomas Huhn present, from Ashville, N.Y.?

Mr. Huhn, you may proceed. When you are finished, your statement will be made a part of the record. If you will, cooperate with our time limitation. It will be appreciated.

STATEMENT OF THOMAS H. HUHN, R.D. 1, ASHVILLE, N.Y.

Mr. HUHN. Thank you.

I wish to submit a short history of one person's injury and the experiences of one community in meeting the rehabilitation needs of this one individual. In my opinion, her experiences and the efforts of the various agencies to meet her rehabilitation needs speak quite directly in defining a specific type of facility that deserves Federal support and extension.

On July 14, 1958, Miss Sharon Hovey, then 16 years old, fell in Genk, Belgium, fracturing a vertebra with resultant almost complete paralysis. At this time she was in Belgium under the Americans Abroad program sponsored by the American Field Service. The Belgian medical authorities went to uncommon lengths in securing

special stretcher from London, and moving poles and trees in Genk to permit a helicopter to transport her to Brussels.

She was joined there by her mother during the 2-month period that elapsed before she could be brought back to the United States by plane. Arrangements for her Belgian medical care and special transport back to the United States were made by the AFS. The neurosurgeons who attended her for this period donated their services as a gesture of good will toward Sharon and in friendship for the United States.

Exchange of medical information between the doctors on both sides of the Atlantic resulted in seeking admission for Sharon at the New York University-Bellevue Institute of Physical Medicine and Rehabilitation in New York City. She was a patient here from September of 1958 until April 1959. Medical diagnosis and treatment, testing, educational and vocational guidance, physical therapy, rehabilitation training and an understanding climate for the necessary adjustment to a severe disability were provided for Sharon at this comprehensive rehabilitation center.

At the time of her discharge in April, she had progressed sufficiently to permit home care. Although her fingers were paralyzed, she had mastered eating, writing, and many ordinary tasks so routine and automatic for normal people. Through special arrangements made by the principal and faculty of her school, she returned to her position in the senior class of Chautauqua Central School in April. She attended class in a wheelchair and by the most intense effort she completed her regular course of work and passed her regents examinations in French and mathematics with excellent grades. Her classmates accorded her the unprecedented honor of choosing her to be the graduation speaker of her own class.

Throughout the course of this experience, Sharon maintained a positive, sunny outlook even while realizing degree by degree the full extent of her disability. What is a shattering misfortune to contemplate by anyone in full health, in Sharon's case was turned into a period of most rapid social and emotional maturity with a newfound appreciation for her own academic and intellectual potential.

Vocational counselors at the institute, in the New York State Division of Vocational Rehabilitation and the guidance counselor in her high school all worked to locate colleges with physical arrangements that would permit her to attend classes in a wheelchair. At the time of her discharge from the institute, it was the opinion of her counselors that her disability was so great that a certain amount of semi-nursing aid care would be required in any residence college climate. The community committee who had formed in a spontaneous movement to help in any necessary ways was faced with the possible need to raise \$10,000 to subsidize two student attendants in a normal college period.

None of the guidance people were successful in locating a register of colleges who accepted students of this degree of disability, combining higher education with integrated services of rehabilitation specialists. The exception was the University of Illinois. Broadcast letters of inquiry to colleges and personal contacts of many interested people repeatedly resulted in references to the University of Illinois as the only university with special arrangements of the physical plant and a developed rehabilitation center an integral part of the university.

Correspondence, personal visits and talks established that here was a place that could offer not only a very broad range of educational and vocational possibilities, but could also offer an objective of independence in daily living and classroom life that heretofore had not seemed possible.

In the period of search by our one community, along with help from some of the most knowledgeable guidance and vocational counselors anywhere, the University of Illinois was the only institution we found in the United States that could offer this combination of educational and rehabilitation opportunities. I am now aware that starts have been made in other universities toward development of integrated rehabilitation facilities.

When Sharon filed entrance application at the University of Illinois and when she was granted an interview, the cold facts of too many qualified applicants and too few vacancies raised doubts about her future. At that time, there were more than 400 applicants with a limit of new students of 40. Sharon was one of the lucky—she was accepted and is today struggling with the academic problems that face every freshman everywhere along with the physical problems of her particular disability.

Those of us who know Sharon have full faith in her eventual success in her final chosen lifework. She will not only achieve independent living, but will contribute her share to our national production of goods and services.

What would have been her vacation had she been in the group of 9 of every 10 applicants who were not admitted? Would she have been a good subject to learn a trade or skill in a sheltered workshop? Would her intellectual and creative potential have been wasted away if she had sat at home, a dependent on her family, waiting for another year and another 1 in 10 chance of acceptance? These were questions that plagued her, her family and her advisers during the period pending college acceptance of her application.

For me these experiences speak eloquently in behalf of extending and redoubling efforts to give opportunity to the disabled to achieve maximum degree of independent living. Through the period I have described I listened to successive reappraisals of the goals or objectives that this girl could achieve. These successive higher goals did not stem from changes in the level of physical ability, but rather, they became possible through the availability of facilities in Belgium, in New York City, her home in Chautauqua County, her school at Chautauqua and now at the University of Illinois.

I have grave doubts that these higher and higher goals would have materialized had there been long waits between availability of the facilities.

In my opinion, H.R. 3465 is sound in objectives and reasonable and feasible in the forward steps it takes toward the independent living goals for handicapped individuals.

I recommend to this subcommittee that it consider adding to section 302(b) a provision making approved university rehabilitation centers eligible for grants in a manner similar to that provided for nonprofit workshops. I realize that the present language of the bill perhaps does not exclude this type of grant under either section 302 or special projects grants under Public Law 565, but neither is it

specified or recognized as a necessary and desirable facility in achieving independent living possibilities for those physically handicapped but mentally fit for vocations requiring university training.

Reasons or arguments supporting this recommendation:

(1) The improvements of diagnostic and treatment facilities have made it possible for more disabled persons to be good candidates for college training. It is wrong to sponsor improvements in diagnosis, treatment and referral and to disregard the needs of facilities to carry out referrals involving higher education.

(2) This move by the Congress would be a most proper area for Federal action. It would be an act of recognition of the initiative and success of individual States and institutions who have pioneered in this joint educational-rehabilitation service.

(3) The integration of rehabilitation and university facilities will stimulate interest and progress in research in vocational rehabilitation. Medical advances in the field of physical medicine have come from specialized rehabilitation centers integrated with medical schools. The integration of rehabilitation and academic institutions will yield similar advancements in our knowledge.

(4) Lastly, in our "pursuit of excellence," in our concern for individual education and development, we should not neglect the intellectual and creative potential as well as physical and workshop skills and potentials of the handicapped. Were we to design a rehabilitation center for a young Franklin D. Roosevelt, had his illness been in his teens, would we not want him to attend a university? Would we be satisfied with a 1-in-10 chance of having space for him at a university?

Thank you very much.

Mr. ELLIOTT. Thank you, Mr. Huhn, for that fine statement.

Again I will call for Sylvia Golden. Is Sylvia Golden here?

Horace Mann?

Bernard Frankel? Come forward, Mr. Frankel.

Mr. Frankel, you may proceed with your statement.

STATEMENT OF BERNARD FRANKEL, EXECUTIVE DIRECTOR, LONG ISLAND CONSULTATION CENTER, FOREST HILLS, N.Y.

Mr. FRANKEL. In my capacity as executive director of the Long Island Consultation Center of Forest Hills, N.Y., one of the large voluntary psychiatric outpatient clinics in the Nation, permit me to state what should be the six general objectives of any comprehensive program of rehabilitation.

These objectives and their implementation have relevance not only to rehabilitation in general, but also to specific handicapping conditions, whether they are physical, mental or both. They are as follows:

(1) Case finding; namely, the location of children and adults within a given geographic area who are in need of rehabilitation.

(2) Direct and ancillary treatment; namely, the correction of the handicapping condition to the extent possible and helping the handicapped person develop attitudes and skills essential to a more satisfying life.

(3) Community understanding; namely, to help the community to move toward a greater understanding and acceptance of the handicapped person's limitations and potentialities.

(4) Family understanding; namely, to help the families of handicapped people to understand and work within the limitations and potentialities of the handicapped person.

(5) Professional recruitment and training; to promote and provide for the recruitment and training of specialists in professional fields related to rehabilitation.

(6) Research; to promote and stimulate research in methods of prevention, early discovery and care of handicapping conditions.

It is clear that these six objectives are interrelated if we can think of rehabilitation in the broad perspective. It is also clear that in the interest of developing local initiative, support, understanding and acceptance of a rehabilitation program, an extensive amount of community mobilization, planning and coordination is needed.

Obstacles in the way of necessary community planning and coordination, whether on the Federal, State, or local level, are primarily lack of funds; duplication on the part of voluntary health agencies in providing similar services for differing handicapping conditions under many different kinds of roofs despite a strong commonality of service needs; lack of agreement on what constitutes adequate rehabilitation standards and practices; gaps in continuity from hospital care to a return of the handicapped person in the community and family; self-centeredness in regard to advancing the interests of special health groups without due consideration of the relative importance of a specific health problem to the total health picture; the increasing barrage of special appeals for public financial support from many different groups which serve to make the public confused, uncertain, and isolated from a broad comprehension of rehabilitation priorities and needs; and finally, the overemphasis on physical, surgical, medical correctional practices in treating handicapped conditions with a consequent underemphasis of psychosocial and adjustive measures to help integrate the handicapped person as a member of his family and the community with the accompanying feelings of self-worth, adequacy, opportunity, and democratic participation in the world of education, recreation, vocational, social, and interpersonal opportunity.

The obstacles I have mentioned are by no means inclusive.

Rehabilitation has become a term that can mean almost anything to anybody. In the minds of some, it may not go beyond braces or other orthopedic devices. In the minds of others, it may not go beyond physiotherapy, speech therapy or hearing aids or seeing-eye dogs. Still to others, it might mean sheltered workshops or special schools.

To my way of thinking, rehabilitation is a total comprehensive integrated approach to a handicapping condition, physical and/or mental, which provide multidisciplinary and/or coordinated services designed to help the individual achieve as full a measure of independence, opportunity, growth and satisfaction as his condition permits, utilizing a maximum of diverse professional skills within a cooperative structure to help in developing the obvious and latent potentialities of the handicapped person.

Chairman BARDEN. That would not be so if it were not for the fact that about half of the people trying to work out a formula or a definition of the very thing you are now discussing—we resorted to calling in some doctors; they did not harmonize.

I hope, with the privilege of filing a statement, you will see if you cannot trim down a statement that would be of assistance to the committee in arriving at a definite definition. Our trouble then was that if we left it open, virtually every interpreter would have a different definition, and if we use the word "shall" and said "It shall be," so and so, we would hardly get it printed before every member of the committee would be a sap, because everybody would find something else that belonged in that definition.

You know doctors, and I am not mad with them at all—I have a son that is a doctor and a son-in-law that is a doctor, so I can't afford to say anything about them, but there is a wide range of disagreement when you begin to try to define a term. I am sure you recognize that fact in using it.

Mr. FRANKEL. Yes, and I certainly agree with you, sir. I feel that it is going to be very difficult to determine what an adequate program should be unless we do arrive at some definition, as long or as short as it might be, because until that point comes, we all will be talking about rehabilitation, but will all perhaps be meaning very different things by it.

Chairman BARDEN. For that reason, we have had to approach it rather cautiously, to keep out of that fog there. It was very clearly brought to your attention that it was existing. The doctors would not even agree on, for instance, the disability accompanying some particular disability that you would refer to.

As an aside from this, I remember very distinctly appointing a boy to Annapolis who was in the Bainbridge camp. He went to headquarters and was examined by two doctors. They reported that he had hypertension, one eye was off, curvature of the spine, and one leg shorter than the other. When I got the report, I said to my secretary, "We better send an ambulance after him." The boy said there was not anything wrong with him. He said, "If I can get out of there, I will get along all right." I immediately applied for his release to go to school for preparation to enter the Academy. They granted that and about 4 months later he appeared at the Academy to enter. He entered as a perfect specimen of manhood, both legs the same length, no hypertension, eyes good, and the boy got along all right.

I should not say that in criticism of the doctors, but I relate it as an extreme example of how far they can get apart. That being so, I do wish you would very clearly define not the maximum, but the clear-cut understandable minimum in your definition. Is that asking too much?

Mr. FRANKEL. Responding to it spontaneously, I would like to boil down my definition of rehabilitation to include a comprehensive, integrated program of multidisciplinary and coordinated services that are designed to help the handicapped person achieve as full a measure of life as possible.

Chairman BARDEN. Don't you think that would be a rather dangerous order to place in the hands of an administrator?

Mr. FRANKEL. I think it would, but I think an advisory committee to such an administrator would be helpful.

Chairman BARDEN. Just after World War I, you would be surprised at the number on the pension rolls for ingrown toenails and flat feet. I am not at all fussing. I really want you to help us. I know what we are going to run into when we try to set the definition.

Mr. FRANKEL. In the latter part of my presentation, sir, I think I indicate some ways in which the Federal Government can enable national health agencies particularly to arrive at some workable definition of rehabilitation, which can then be translated into an integrated kind of a program.

Chairman BARDEN. I know exactly what you are referring to. I was trying to just quietly get a little information that would be helpful.

Excuse the interruption.

Mr. FRANKEL. I think your interruption is appreciated by me, so I will not continue completing my definition because it is still on the long side. But I hope that the one I substitute for it nevertheless makes just as valid a point, although somewhat shorter.

Let us attack the problem of meeting the needs of the handicapped by agreeing first on what we mean by rehabilitation, by arriving at some consensus of agreement wherein we are all talking in the same language and can assess what at least are the minimal standards for adequate rehabilitation programs.

Let us then, by survey, research and evaluation of current programs, put out fingers upon these gaps and shortages that undermine, prevent, or limit what we feel are the prerequisites for an adequate rehabilitation program.

Speaking as a mental health clinician, let me state from my experience what I believe are the most critical unmet needs in rehabilitation in the field of disabling emotional and neurological handicaps.

Firstly, let me deal with the mentally ill, which has often been called America's No. 1 health problem. Public facilities for the mentally ill adult and child are nowhere near a comprehensive rehabilitation program. While the advent of drug therapy has in many instances shortened the period of hospitalization, there are still critical shortages of psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, and attendants.

Psychotherapy, counseling and casework is primarily distributed on a sporadic and uneven basis. Most importantly, the link between hospital care and return to the community is very thin. This is most true in the areas of aftercare and regular followup, vocational training and placement, family preparation for the discharged patients, and recreational opportunities.

For the mentally ill child, there are few residential treatment or specialized institutional facilities, few outpatient available clinical facilities, hardly any specialized public educational facilities for the child who lives at home, and few all-day integrated treatment and educational centers.

Next come the mentally retarded. Again one wonders about the high incidence of institutional placement because facilities are nonexistent or inadequate for the child or adult who might be living at home, were it not for the absence of community facilities.

One wonders about institutional care and whether it is rehabilitative or preponderantly custodial in nature. In the community, there is a dearth of diagnostic and treatment facilities. There is a severe shortage of specialized educational facilities, trained teachers, and clinicians.

Recreational opportunities and sheltered workshops are sparse. Community attitudes of stigma even prevent adequate case finding. Speech therapists and remedial educational clinicians are few. There is a tremendous ignorance and a distorted hopelessness about the potentialities of the retarded person.

Research is barely minimal. Education, guidance, and counseling of parents is generally forgotten. Parents of young children where retardation is suspected have had to wait 2 to 3 years before they could use the services of a diagnostic clinic.

Next come the neurologically disabled and the brain-injured children and adults. Again the same shortages of clinical facilities as well as educational, vocational, and recreational opportunities. Research is at a most rudimentary level.

For the mentally ill, the retarded, and the brain injured, many doors are closed. National voluntary organizations that were formed to promote public awareness and to improve or create services for these handicapped groups grew out of the desperate needs of families and parents who joined together to combat community indifference and ignorance.

I could continue citing unmet needs and rehabilitation priorities in other areas of health where there are handicapping conditions. The handicapped, their parents and families, and the professionals who work with them, are aware for the most part of what is needed.

In my opinion, the Federal Government ought to broadly function on two main levels aside from specific and concrete legislative action to meet special needs of one handicapped group or another.

The first level should be that of an enabler. To bring together through conferences and meetings on a regular basis the national health agencies concerned with handicapping conditions, in order to arrive at accepted formulations and standards of adequate rehabilitation.

Secondly, through financial support on a demonstration basis possibly in partnership with foundations, State and municipal bodies, the Federal Government ought to underwrite programs of existing community councils on the local level, where the community council can provide a sound plan for comprehensive rehabilitation planning, involving the local health agencies, public and private in line with the six objectives mentioned previously.

In this way, local initiative, autonomy and eventual support will replace by community response the initial enabling function of the government. Avoidance of duplication, integrated effort, consensual agreement, cooperation and joint implementation can be best handled by existing planning and coordinating agencies on the local level.

Thank you very much.

Mr. ELLIOTT. Thank you, Mr. Frankel.

At this point may I say that the full Committee on Education and Labor authorized our Subcommittee on Special Education to undertake early this past year, in the spring of this past year, a study that

we call our special education and rehabilitation study. That study is under the direction of Dr. Merle Frampton.

The study group, at the same time we have been operating here, has been working on what it calls a New York study workshop. I would like to ask Dr. Frampton if the people from the workshop are ready to report and, if so, Dr. Frampton, you may present them.

Dr. FRAMPTON. Yes, Mr. Chairman, your study group has been working for 2 days covering all the contents under the jurisdiction of this committee. There were in the sessions approximately 250 professionals from throughout the length and breadth of the State of New York. They formed themselves into eight major committees and elected their own chairmen and cochairmen. They are ready to report to your committee their findings.

They have been working hard, some of them burning midnight oil, and some of them may not even be here for the next half hour, because they are still at the reports. If some of the reports do not come in, we beg your indulgence and ask the privilege of inserting them in the record of this meeting, to be sent around to all of them. But I think maybe they will be here before the meeting has been completed.

The names of the chairmen and cochairmen you have before you, Mr. Chairman. If you will call on them as they appear, they will come forward and identify themselves. The committee should be very grateful, and I am sure you are, for this wonderful expression of their interest in their own professional fields. They have worked without any compensation, long hours, to bring before you the best thinking at the moment in this field.

Mr. ELLIOTT. The Chair recognizes the gentleman from North Carolina.

Chairman BARDEN. I wanted to say this in behalf of the whole committee which, as you probably know, consists of 30 Members of Congress: that the invitation in the State of New York was sent by Mr. Elliott, chairman of the subcommittee, and just as near a full and complete list of every group interested in this was sent out—and I think you sent out invitations to about 400.

Mr. ELLIOTT. Several hundred. I do not have the exact number.

Chairman BARDEN. I say that because sometimes when we attempt to enter a field, there is always somebody that says, "Well, they just have a pet group." We do not want a pet group. This committee, consisting of 30 members, would like to have the very best possible cross section of the best thinking of those who know the most about the subject.

Then we take that information and do the best we can with it. I thought that might be worthwhile as a word of explanation of the activities of the committee.

Dr. FRAMPTON. The first group, I believe, is the blind group on your list. They are ready to report.

Mr. LAFORE. Is this reporting by virtue of the eight categories?

Mr. ELLIOTT. Yes.

The reporting is on the basis of the eight workshop groups, or the eight categories, maybe we should say. The first group to report is the section on the blind, which was chaired by Dr. Peter Salmon and

cochaired by Dr. Eber Palmer. Dr. Salmon is with us. Is this Dr. Palmer?

Dr. SALMON. Yes. I will be very brief, Mr. Chairman.

**STATEMENTS OF DRS. PETER J. SALMON AND EBER L. PALMER,
COCHAIRMAN, WORKSHOP ON SPECIAL EDUCATION OF THE
BLIND**

Dr. SALMON. We would like to have the committee hear the report of the invitees who sat in relation to the field of work for the blind at the very kind invitation of your subcommittee.

We did have, and we have a list of those who attended, a complete representation, I think, of the various interests in work for the blind in New York State. We do not always agree with each other. As a matter of fact, I can remember in 1943 when the chairman of your committee, the full committee chairman, that is, did not have as much courage as he has today in getting work for the blind in one room. We just could not be in the same room at that time.

However, a lot has gone over the dam since then. We love to be in one room together. This report represents probably the closest thing to a concentration and a representation of the varying views of those who work with the blind and those who are workers for and those who are workers of the blind.

The method or approach that we made was this: We stated the problem and then we discussed it, and then we made a proposal. We arrived at a consensus. That is what we would like to present to you now. Thank you very much.

Dr. Palmer and myself as cochairmen worked together. We had separate meetings the first meetings. The first day, October 27, was for special education, and the second day, October 28, was for rehabilitation. We completed this report at 2 o'clock this afternoon. We are very happy to present it to you.

Mr. ELLIOTT. Dr. Salmon, let me ask you a question or two.

Do you mean the report that you bring us is the report that the entire group agreed upon?

Dr. SALMON. Yes, sir; positively.

Mr. ELLIOTT. Was it unanimous?

Dr. SALMON. We have stated we had a majority report on all items. In many items we had a unanimous report. Wherever there was a desire for a minority statement, we recorded that.

I think we have only two instances where persons wished to make a minority statement. But we invited minority statements on every single item. There is not one person that did not realize that.

Mr. ELLIOTT. And apparently there were about 36 people in this workshop group; is that right?

Dr. SALMON. It was a little more than that. I think there were probably closer to 60, taking the 2 days together.

Mr. ELLIOTT. The gentleman from New York, Mr. Wainwright, desires to ask you a question, Dr. Salmon.

Mr. WAINWRIGHT. Dr. Salmon, we have made reference to our full committee chairman's courage in what he did in the old days and what he does today in getting you people together. Do you have in here mention of the man who heads the group of the blind from California?

Dr. SALMON. Do you mean Mr. tenBrook?

Mr. WAINWRIGHT. Yes. Was he a representative?

Dr. SALMON. Mr. Taylor sat in as an observer, but he did not sit in as an invitee. He sat in and was very helpful in giving us information. Mr. Taylor did not vote on the various items and he did not sit in on all of the sessions.

Mr. WAINWRIGHT. Do not they represent a large segment?

Dr. SALMON. Yes. We invited and had the representative, Mrs. Mary Jane Hills, president-elect of the Empire State Association of the Blind, which is the affiliate of the National Federation of the Blind here in New York State. Our assignment, Mr. Wainwright, was to devote ourselves to problems of New York State that might have a Federal implication.

But where there was a national organization that had an interest, we invited them, and we did invite Mr. Taylor to sit in with us. He sat in for part of the meeting as an observer.

Mr. WAINWRIGHT. Mr. Taylor was the representative of that group?

Dr. SALMON. Yes, Mr. John Taylor.

Mr. WAINWRIGHT. We had hearings earlier this year by this same subcommittee, conducted by Mr. Elliott, and it was brought out at the time that a very large segment of the blind, and certainly one philosophy of care for the blind, was represented by Dr. tenBrook. I was interested in whether spokesmen for that philosophy were represented in this.

Dr. SALMON. Yes, they were, in the Empire Association for the Blind of New York State, an affiliate.

Mr. WAINWRIGHT. But you said they did not vote?

Dr. SALMON. The Empire affiliate did; yes, indeed.

Mr. WAINWRIGHT. Not Dr. Taylor?

Dr. SALMON. No, because they have an affiliate, a chapter, here in New York State, which is an affiliate of the national federation, called the Empire Association for the Blind.

Mr. WAINWRIGHT. Those are very progressive steps, getting those groups together.

Dr. SALMON. Yes. We were very happy and we appreciate their cooperation very much.

Dr. Palmer is the cochairman and he will be able to read this more quickly than I can, because he went further in school than I did.

Dr. PALMER. I may be one of those who went further in school but did not get as far.

As Dr. Salmon told you, we took up the problem and then the proposal. Incidentally, for your information, this was not necessarily a group of seeing people passing judgment upon what is best for those who are without sight, because we were very well represented in the group by those also who are without sight and who could express an opinion not only as a professional worker, but as individuals who had gone through this process of loss of vision or having no vision.

Therefore, it represents the consensus of those professional workers who see and also those who are without sight. I wanted to be sure that you understood that it covered that.

There are a lot of problems and a lot of proposals. I am going to start reading and I will leave it to the discretion of the chairman to stop me whenever he feels that he wishes to.

MR. PALMER. The section on special education of the blind herewith presents a summary of its deliberations in the meeting held on October 27, 1959. A list of those who attended is attached.

In the course of the discussion the question of the partially blind child was raised on occasion. The workshop group felt that since there was a section deliberating on the question of the visually handicapped child any matters relating to the visually handicapped should be referred to it.

The workshop on the blind referred to the workshop on the visually handicapped problem 1, proposal (a) below, in which it was felt that possibly some provision should be made for consideration of the visually handicapped group as well as the blind.

We are very pleased to report that on all proposals except No. 8, there was unanimous agreement, and on No. 8 there was substantial majority agreement.

Problem 1: Statewide experience in the problem of securing teachers and the limited resources available for the training of teachers affects the soundness with which the community can deal with these problems.

Even with a concentrated program such as that offered by the schools and some public and private agencies for the blind, the problem of securing teachers and of recommending educational resources for the training of teachers has been profound, and is even more marked in areas of the Nation where lesser services or no services are available.

In these areas geographic isolation and the small numbers of children involved make some kind of State and regional planning essential.

PROPOSALS

(a) A highly qualified consultant and staff on the education of blind children should be added to the Department of Health, Education, and Welfare in the Office of Education, section for exceptional children and youth;

(b) The amendment of Public Law 85-926 to include all types of exceptionality on a categorical basis would be highly desirable. The extension of this law to provide direct teacher training for teachers of blind children on an undergraduate or graduate level and administrators and teachers of teachers as well, is not only desirable, but highly essential.

If this creates any legislative problem, a new bill should be proposed to accomplish this end.

Problem 2: Because of the severity of the handicap of blindness, it is recognized that effective and early case finding, diagnosis, educational counseling, family counseling, and other indicated community services are essential for the blind child and his family.

In order to create a climate within which the child can receive the affection and stimulation needed if he is to develop the potential with which he is endowed, the services of the various disciplines are needed over a long period of years in varying degrees of intensity.

There exists a nationwide shortage of trained professional workers in all areas of service for the blind child.

In addition, the present curriculum in professional schools provides a generic approach to their professional disciplines. The specialized

area of service to blind children and to their families requires curriculum and field experience in addition to generic training.

PROPOSALS

We suggest that:

(a) Specialized instruction and field services be made available in the handling of the problems of blindness, and that Federal funds in the form of grants-in-aid, including scholarships or fellowships be made available to professional schools to interest students in entering the field of service to blind children, and that financial assistance be granted to such schools to include the essential courses in their curriculums not currently offered.

It is also recommended that such grants, in addition to current support, be sufficient to carry the costs of field supervisory staff, selected for the purposes of student training by agencies for the blind having professionally qualified staffs in the various disciplines.

(b) Because of the geographic distribution of blind children and the comparative isolation of these children in many areas, the social caseworker or the child welfare or public assistance worker is frequently the only person providing any service to the family of a blind child.

It is, therefore, apparent that insofar as possible some national approach to the education of social workers should be attempted so that they will have the essential understanding of the problems of blindness.

Similarly, members of other professions may have heavy responsibilities in serving blind children. They, too, will need preparation in understanding the problems of blindness.

(c) In addition to the full curriculum the professional schools should receive Federal funds and encouragement to provide training seminars or intensive short-term training courses for practitioners.

(d) The professions include psychology, social work, educational counseling, speech therapy, and others concerned in the growth of blind children.

(e) These funds should be applied for training purposes over and above what is currently offered.

Problem 3: We are fully aware that all of the national and local organizations concerned with the publication and distribution of books and equipment for the education of blind children have been struggling with the problem, which they have been unable to resolve.

Equality of education for blind and seeing children cannot be maintained without equality of books and equipment. Adequate books and equipment make the choice of educational opportunity possible to the parents of blind children. The blind child should not have to depend upon volunteer effort for its essential educational needs.

PROPOSALS

We would suggest that:

(a) The Library of Congress be empowered to purchase any or all needed books or devices from any reputable source, and to make such books and equipment available for educational purposes to blind children in public, private, and parochial schools.

(b) The American Printing House for the Blind be encouraged to expand its facilities and be permitted and encouraged to subcontract for the manufacture of finished products, either books, machines, or equipment, from any established and reputable source, and that its distribution quota be expanded to take care of all of the needs of each State without regard to the present money limitation of \$30 on a per capita basis in public, private, and parochial schools, and that the present authorization of \$400,000 be abandoned and an open end authorization be planned, at least during this period of emergency.

(c) Adequate funds be made available to the American Printing House for the Blind for:

(1) The expansion of its administrative personnel to meet its own needs, which would include trained persons for area assignment to the States to expedite liaison between them and the printing house; and

(2) Federal funds be made available through the American Printing House for the Blind for the employment of personnel to carry the program forward within the States.

This latter could be done either wholly by Federal funds or on a Federal-State participating basis.

(d) Funds be made available to the Library of Congress to expand its proofreading program, accelerating the certification of proofreaders, increasing the payment to proofreaders, and liberalizing its application of proofreading regulations to include reimbursement for proofreading on a local basis to public and private agencies and to public, private, and parochial schools.

(e) Funds be made available for education and technological research.

In this case, there was a minority point, and with your permission, I will read the minority point.

Chairman BARDEN. May I ask this question:

Does the minority viewpoint relate to all of the matter that you have read?

Mr. PALMER. Basically, no. That only deals with the matter of obtaining copyright permissions.

Mr. DANIELS. Item No. 3?

Mr. PALMER. That is right.

Minority viewpoint: In circumstances wherein Federal Government funds are currently appropriated to defray the expenses of reproducing copyrighted materials in Braille, suitable for use of blind persons, it is proposed that a system which affords the publisher holding the copyright a reasonable remuneration for the use of such materials, if such remuneration is required to secure permission to reproduce such material, be employed, and adequate funds be appropriated for this purpose.

Problem 4: The present high incidence of blindness among children has created a situation which is ideal for the study of the problems of the development of normal blind children, and even more particularly of the educational treatment and care of multihandicapped blind children.

However, the pressure of meeting basic, rudimentary, educational needs has been so great that little study has been possible.

Such research in relation to blind children holds rich promise of its application to other types of handicapped children, particularly those children with congenital handicaps and organic brain damage.

In our group, we tried to keep specifically within our area of the blind.

Enough evidence has been accumulated and enough special skill has been applied to the problem to indicate the need for intensive study during this period.

PROPOSALS

(a) We therefore suggest that consideration be given to the application of existing Federal laws making funds available for research purposes, which might be applied to this problem.

In particular, Federal funds should be made available for the development of facilities which could carry out valuable research while providing services to render the multihandicapped blind child able to cope more effectively with his environment.

(b) The Department of Health, Education, and Welfare should encourage collaborative research on blind and visually handicapped children involving medical, social, technological factors.

Such research should be long term and the full cost should be covered by grants-in-aid or by contracts.

Problem 5: The New York State study of services to blind children identifies a large number of children with severe impairments or other problems in addition to blindness. For many of these children the impairment is such that it prevents their benefiting from existing educational programs.

In view of this, there is urgent need for appropriate diagnostic and treatment facilities if their potential for education and for productive living is to be salvaged.

Unless appropriate services can soon be developed, this potential will have been destroyed and these children will become nonproductive and economically and physically dependent on governmental funds for their continued existence.

PROPOSALS

We suggest that:

(a) Diagnostic treatment centers be provided to serve States or regional needs.

It is recommended that these centers receive Federal support, both for capital and operating expenses.

(b) Aside from the usual educational content of special education, the State and Federal Governments in cooperation should purchase services from qualified private agencies to provide services where existing public agencies cannot meet the need, and to make possible the inclusion of all aspects of rehabilitation necessary for the maximum functioning of the individual child.

(c) In order to deal effectively with the mental and emotional problems of blind children, Federal mental health funds should be made available for implementation of specialized programs of care, rehabilitation, and mental hygiene services for these children.

Such specialized funds might provide services either separately or in conjunction with specialized agencies equipped to provide effective programs, not only in direct treatment, but in research.

Problem 6: The experience of the past 10 years of the enormously increased need for educational services for blind children has provided substantial evidence for the need of a broad supportive Federal program in the field of the education of blind children.

PROPOSALS

We would suggest that:

(a) A formula for substantial Federal participation in the extra costs of the special education of blind children needs to be explored.

(b) If a blind child is to secure adequate education and have an equal choice of educational opportunities with a seeing child, we would urge that vocational guidance and training be included in the structure of the education of blind children at the elementary and secondary school levels, and that Federal funds be made available through grants-in-aid to implement this goal.

(c) The various offices of the Department of Health, Education, and Welfare, the Office of Education, Section for Exceptional Children and Youths, and the Office of Vocational Rehabilitation in particular, should be urged to take the leadership in this area and to apply their skills to the problem through the development of in-training seminars, guidance clinics, and courses specifically geared to the need of blind children in elementary and secondary schools.

Problem 7: It has been clear to the field of work for the blind and in the area of the education of the blind children, that the distribution of grants-in-aid for research and other programs needs special review.

There is evidence that funds have not been applied to research and problems concerning blind children as has been the case with respect to other disabilities.

At present most grants require such rigid medical or university orientation as to make it impossible for work for the blind to take advantage of these funds.

Moneys available through Public Law 482 or Public Law 565, become more and more difficult to secure and, in particular, funds under the National Defense and Education Act have been denied to schools for the blind and for the deaf for the furtherance of scientific and mathematical education.

PROPOSAL

Since there is greater need for Federal funds in research to be put into problems concerning blind children and need for the program to be further extended to include competent facilities in addition to university or medical settings, we propose that the Department of Health, Education, and Welfare be urged and encouraged to change its thinking and relax its attitude on the matter of providing grants for other than medical or university purposes, and that such funds as are available to be used on the basis of the merits of the application for the grant by the States and of the qualifications of the proposed research staff.

Problem 8: Apart from direct service needs of blind children, attention should be given to easing some of the major financial pressures borne by parents of these children by providing an amendment to the Internal Revenue Code to permit an extra tax exemption for the blind

dependent child. Parents of blind children face extra expenditures because of the blindness of the child which are not incurred in relation to the normal sighted child.

This added expense has already been recognized by the Internal Revenue Code in relation to blind taxpayers.

PROPOSAL

We would, therefore, propose that the Internal Revenue Code be amended to achieve this end by creating an additional exemption for the blind dependent of the taxpayer.

Problem 9: Despite the fact that reading matter for the blind, in either braille or on talking book records, may now be mailed directly to blind persons and from them to other sources of free charge, the limitation of 15 pounds of such materials is unrealistic in view of their extreme bulk.

PROPOSAL

We, therefore, suggest that an amendment to the present postal regulations be sought so that all educational material for the blind, regardless of weight, may be sent through the mails without charge.

This concludes the discussions in the report and proposals on the first day of the workshop. That deals with education.

The second portion deals with rehabilitation.

Mr. SALMON. I hope he will be willing to hear the second section. We would appreciate it if you could. We have worked very hard to prepare this document.

Chairman BARDEN. I am certainly going to read it, because to me this is a very valuable document.

Mr. SALMON. I might say the question was asked about the voting. We can give you, if the committee desires, the vote on each particular item, if that is of any interest at all.

Mr. WAINWRIGHT. In my case, Dr. Salmon, all I was asking before was not to ascertain whether there had been any differences, or whether the differences had been settled, but more or less to get the concept that all views had been represented.

Mr. SALMON. I can only say that I have been working with this group for many, many years, and I don't think we have ever sat down and resolved more problems than we did in these 2 days.

I think it largely stems from the fact that the group appreciates very sincerely that here is a unique opportunity that has been offered to them by the committee to present problems and proposals.

Whether or not the committee in its ultimate judgment can accept some of these, or all of these, or any of them, we feel that this kind of situation has never existed before and we wanted to take full advantage of it.

I think that is why the group came to these conclusions.

Mr. WAINWRIGHT. Also, I wanted to make clear, particularly for Dr. Palmer after his opening statement, that I am not in the least in sympathy with the totalitarian viewpoint of this group, personally, that is, but I wanted to make sure that at least their views were represented.

Mr. PALMER. My supplementary remarks were merely to add to what Peter Salmon already said, that those who were present, the Empire

State Association, the National Federation for the Blind, were not the only blind persons in attendance. There were others as well, who represented other areas.

Mr. WAINWRIGHT. But you touched right on the core of the difficulty.

Chairman BARDEN. May I ask one question while we are on that?

Mr. ELLIOTT. Mr. Barden.

Chairman BARDEN. In the past years when I was chairman, I remember handling two or three increases, and they were justified, for the American Printing House for the Blind. Is that not in Tennessee?

Mr. SALMON. It is in Kentucky, Louisville.

Chairman BARDEN. Yes, in Kentucky.

The last time or two the bill has been sponsored by a Kentuckian. I do remember that.

You know more about the inside of that than I do. Could not an amendment to the act on the American Printing House for the Blind take care of this?

Mr. SALMON. That might. The real situation is that over the past 10 or 15 years there has been a great diversification of the educational processes, and there is an increasing need for individual textbooks, one and two volumes at a time.

The American Printing House has been able to do a very excellent job with respect to the bulk printing. But these one and two text volumes become a great problem.

On Long Island, in Nassau and Suffolk Counties alone, we have 600 or 800 persons who devote themselves to braille and transcribing individual books for blind persons.

Chairman BARDEN. The reason for the increase in the appropriations of the American Printing setup was the increase in cost of materials and the increase in cost of the labor and everything else that went into it.

Mr. SALMON. That is part of it; yes.

Chairman BARDEN. I was not fussing with them about that at all. But when we started to handle a major piece of legislation, every time we can put something like that somewhere where it will not bother, it is better.

Mr. SALMON. We will be able to supply you with more detailed facts on the items as you study the items that become important. We felt that even though this is rather lengthy, that we should make it as concise as possible at this stage, and then if the committee is interested, we, all of us, the American Foundation for the Blind, I am sure the national federation, the printing house, and all of the group involved, will be glad to supply any and all information you might require.

Chairman BARDEN. By way of maybe a little sympathy for the chairman, I know he wants to hear every word of all of the reports, but I doubt if the clock is going to move that slowly.

Do you have about eight?

Mr. ELLIOTT. Yes, we have eight.

Mr. SALMON. We will be glad to yield, Mr. Chairman. We appreciate the opportunity to present this to you. We know you will read it.

Chairman BARDEN. I cannot help but wonder why you had to be 20 years late.

Mr. SALMON. It takes a long time to get out of Brooklyn, you know.

Mr. PALMER. Or to New York from Batavia.

Mr. SALMON. And getting back is more difficult.

Chairman BARDEN. I think it will be studied by all members of the committee.

Mr. PALMER. May I say, Mr. Barden, there was no intent on the part of our particular workshop because of the fact that we read that part on education first, to indicate that we felt, although I happen to be in the educational field myself, that that is most important. We feel that they are equally important, but one had to come first.

Chairman BARDEN. Sometimes I wonder if I am in the educational field of if it is on me.

Mr. SALMON. We feel they overlap.

Mr. PALMER. We appreciate very much your kindness.

Mr. ELLIOTT. Thank you, gentlemen. It is a fine report and we will study it carefully. You have been very kind.

(The formal reports follow:)

REPORT OF WORKSHOP ON SPECIAL EDUCATION OF THE BLIND

Cochairmen: Dr. Peter J. Salmon, Dr. Eber L. Palmer

The section on special education of the blind herewith presents a summary of its deliberations in the meeting held on October 27, 1959. A list of those who attended is attached.

In the course of the discussion the question of the partially sighted blind child was raised on occasion. The workshop group felt that since there was a section deliberating on the question of the visually handicapped child any matters relating to the visually handicapped should be referred to it. The workshop on the blind referred to the workshop on the visually handicapped problem 1, proposal (a) below, in which it was felt that possibly some provision should be made for consideration of the visually handicapped group as well as the blind.

We are pleased to report that on all proposals except No. 8 there was unanimous agreement, and on No. 8 there was substantial majority agreement.

PROBLEM 1

Statewide experience in the problem of securing teachers and the limited resources available for the training of teachers affects the soundness with which the community can deal with these problems. Even with a concentrated program such as that offered by the schools and some public and private agencies for the blind, the problem of securing teachers and of recommending educational resources for the training of teachers has been profound, and is even more marked in areas of the Nation where lesser services or no services are available. In these areas geographic isolation and the small numbers of children involved make some kind of State and regional planning essential.

PROPOSALS

(a) A highly qualified consultant and staff on the education of blind children should be added to the Department of Health, Education, and Welfare in the Office of Education, Section for Exceptional Children and Youth.

(b) The amendment of Public Law 85-926 to include all types of exceptionality on a categorical basis would be highly desirable. The extension of this law to provide direct teacher training for teachers of blind children on an undergraduate or graduate level and administrators and teachers of teachers as well, is not only desirable but highly essential. If this creates any legislative problem, a new bill should be proposed to accomplish this end.

PROBLEM 2

Because of the severity of the handicap of blindness, it is recognized that effective and early case finding, diagnosis, educational counseling, family counseling, and other indicated community services are essential for the blind child and his family. In order to create a climate within which the child can receive the affection and stimulation needed if he is to develop the potential with which he is endowed, the services of the various disciplines are needed over a long period of years in varying degrees of intensity. There exists a nationwide shortage of trained professional workers in all areas of service for the blind child. In addition, the present curriculum in professional schools provides a generic approach to their professional disciplines. The specialized area of service to blind children and to their family requires curriculum and field experience in addition to generic training.

PROPOSALS

We would suggest that:

(a) Specialized instruction and field services be made available in the handling of the problems of blindness, and that Federal funds in the form of grants-in-aid, including scholarships or fellowships be made available to professional schools to interest students in entering the field of service to blind children, and that financial assistance be granted to such schools to include the essential courses in their curricula not currently offered. It is also recommended that such grants, in addition to current support, be sufficient to carry the costs of field supervisory staff, selected for the purpose of student training by agencies for the blind having professionally qualified staffs in the various disciplines.

(b) Because of the geographic distribution of blind children and the comparative isolation of these children in many areas, the social caseworker or the child welfare or public assistance worker is frequently the only person providing any service to the family of a blind child. It is therefore apparent that insofar as possible, some national approach to the education of social workers should be attempted so that they will have the essential understanding of the problems of blindness. Similarly, members of other professions may have heavy responsibilities in serving blind children. They, too, will need preparation in understanding the problems of blindness.

(c) In addition to the full curriculum the professional schools should receive Federal funds and encouragement to provide training seminars or intensive short-term training courses for practitioners.

(d) The professions include psychology, social work, educational counseling, speech therapy, and others concerned in the growth of blind children.

(e) These funds should be applied for training purposes over and above what is currently offered.

PROBLEM 3

We are fully aware that all of the national and local organizations concerned with the publication and distribution of books and equipment for the education of blind children have been struggling with the problem, which they have been unable to resolve. Equality of education for blind and seeing children cannot be maintained without equality of books and equipment. Adequate books and equipment make the choice of educational opportunity possible to the parents of blind children. The blind child should not have to depend upon volunteer effort for its essential educational needs.

PROPOSALS

We would suggest that:

(a) The Library of Congress be empowered to purchase any or all needed books or devices from any reputable source, and to make such books and equipment available for educational purposes to blind children in public, private, and parochial schools.

(b) The American Printing House for the Blind be encouraged to expand its facilities and be permitted and encouraged to subcontract for the manufacture of finished products—either books, machines, or equipment—from any established and reputable source, and that its distribution quota be expanded to take care of all of the needs of each state without regard to the present money limitation of \$30 on a per capita basis in public, private, and parochial schools, and that the present authorization of \$400,000 be abandoned and an open-end authorization be planned, at least during this period of emergency.

(c) Adequate funds be made available to the American Printing House for the Blind for (1) the expansion of its administrative personnel to meet its own needs which would include trained persons for area assignment to the States to expedite liaison between them and the Printing House; and (2) Federal funds be made available through the American Printing House for the Blind for the employment of personnel to carry the program within the States. This latter could be done either wholly by Federal funds or on a Federal-State participating basis.

(d) Funds be made available to the Library of Congress to expand its proof-reading program, accelerating the certification of proofreaders, increasing the payment to proofreaders, and liberalizing its application of proofreading regulations to include reimbursement for proofreading on a local basis to public and private agencies and to public, private, and parochial schools;

(e) Funds be made available for educational and technological research.

MINORITY VIEWPOINT

In circumstances wherein Federal Government funds are currently appropriated to defray the expenses of reproducing copyrighted materials in braille, suitable for use of blind persons, it is proposed that a system which affords the publisher holding the copyright a reasonable remuneration for the use of such materials, if such remuneration is required to secure permission to reproduce such material, be employed, and adequate funds be appropriated for this purpose.

PROBLEM 4

The present high incidence of blindness among children has created a situation which is ideal for the study of the problems of the development of normal blind children and even more particularly of the educational treatment and care of multihandicapped blind children. However, the pressure of meeting basic, rudimentary, educational needs has been so great that little study has been possible. Such research in relation to blind children holds rich promise of its application to other types of handicapped children, particularly those children with congenital handicaps and organic brain damage. Enough evidence has been accumulated and enough special skill has been applied to the problem to indicate the need for intensive study during this period.

PROPOSALS

(a) We, therefore, suggest that consideration be given to the application of existing Federal laws making funds available for research purposes which might be applied to this problem. In particular, Federal funds should be made available for the development of facilities which could carry out valuable research while providing services to render the multihandicapped blind child able to cope more effectively with his environment.

(b) The Department of Health, Education, and Welfare should encourage collaborative research on blind and visually handicapped children involving medical, social, technological factors. Such research should be long term and the full cost should be covered by grants-in-aid or by contracts.

PROBLEM 5

The New York State study of services to blind children identifies a large number of children with severe impairments or other problems in addition to blindness. For many of these children the impairment is such that it prevents their benefiting from existing educational programs. In view of this, there is urgent need for appropriate diagnostic and treatment facilities if their potential for education and for productive living is to be salvaged. Unless appropriate services can soon be developed, this potential will have been destroyed and these children will become nonproductive and economically and physically dependent on governmental funds for their continued existence.

PROPOSALS

We would suggest that—

(a) Diagnostic and treatment centers be provided to serve State or regional needs. It is recommended that these centers receive Federal support both for capital and operating expenses.

(b) Aside from the usual educational content of special education, the State and Federal Governments in cooperation should purchase services from qualified private agencies to provide services where existing public agencies cannot meet the need, and to make possible the inclusion of all aspects of rehabilitation necessary for the maximum functioning of the individual child.

(c) In order to deal effectively with the mental and emotional problems of blind children, Federal mental health funds should be made available for implementation of specialized programs of care, rehabilitation, and mental hygiene services for these children. Such specialized funds might provide services either separately or in conjunction with specialized agencies equipped to provide effective programs, not only in direct treatment but in research.

PROBLEM 6

The experience of the past 10 years of the enormously increased need for educational services for blind children has provided substantial evidence for the need of a broad supportive Federal program in the field for the education of blind children.

PROPOSALS

We would suggest that:

(a) A formula for substantial Federal participation in the extra costs of the special education of blind children needs to be explored.

(b) If a blind child is to secure adequate education and have an equal choice of educational opportunities with a seeing child, we would urge that vocational guidance and training be included in the structure of the education of blind children at the elementary and secondary school levels, and that Federal funds be made available through grants-in-aid to implement this goal.

(c) The various offices of the Department of Health, Education, and Welfare—the Office of Education, Section for Exceptional Children and Youth, and the Office of Vocational Rehabilitation in particular, should be urged to take the leadership in this area and to apply their skills to the problem through the development of intraining seminars, guidance clinics, and courses specifically geared to the need of blind children in elementary and secondary schools.

PROBLEM 7

It has been clear to the field of work for the blind and in the area of the education of blind children that the distribution of grants-in-aid for research and other programs needs special review. There is evidence that funds have not been applied to research and problems concerning blind children as has been the case with respect to other disabilities. At present most grants require such rigid medical or university orientation as to make it impossible for work for the blind to take advantage of these funds. Moneys available through Public Law 482 or Public Law 565 become more and more difficult to secure, and in particular, funds under the National Defense and Education Act have been denied to schools for the blind and for the deaf for the furtherance of scientific and mathematical education.

PROPOSAL

Since there is greater need for Federal funds in research to be put into problems concerning blind children and need for the program to be further extended to include competent facilities in addition to university or medical settings, we propose that the Department of Health, Education, and Welfare be urged and encouraged to change its thinking and relax its attitude on the matter of providing grants for other than medical or university purposes, and that such funds as are available to be used on the basis of the merits of the application for the grant by the States and of the qualifications of the proposed research staff.

PROBLEM 8

Apart from direct service needs of blind children, attention should be given to easing some of the major financial pressures borne by parents of these children by providing an amendment to the Internal Revenue Code to permit an extra tax exemption for the blind dependent child. Parents of blind children face extra expenditures because of the blindness of the child which are not incurred in relation to the normal-sighted child. This added expense has

already been recognized by the Internal Revenue Code in relation to blind taxpayers.

PROPOSAL

We would therefore propose that the Internal Revenue Code be amended to achieve this end by creating an additional exemption for the blind dependent of the taxpayer.

PROBLEM 9

Despite the fact that reading matter for the blind, either in braille or on talking book records, may now be mailed directly to blind persons and from them to other sources free of charge, the limitation of 15 pounds of such materials is unrealistic in view of their extreme bulk.

PROPOSAL

We therefore suggest that an amendment to the present postal regulations be sought so that all educational material for the blind, regardless of weight, may be sent through the mails without charge.

THOSE WHO ATTENDED WORKSHOP FOR THE BLIND ON TUESDAY, OCTOBER 27, 1959

Dr. Peter J. Salmon, executive director, cochairman, the Industrial Home for the Blind.

Dr. Eber L. Palmer, superintendent, cochairman, New York State School for the Blind.

Herbert R. Brown, director, Vocational Rehabilitation Service for the Blind, Department of Social Welfare.

Peter DeVasto, president, Parents of Blind Children Association, Brooklyn-Queens.

Mrs. Mary K. DeWitt, managing director, Blind Work Association, Inc.

Sr. M. Floretta, O. P. superintendent, Lavelle School for the Blind.

Sr. Jean Marie, O. P., Lavelle School for the Blind.

Anthony Cimino, New York State School for the Blind.

Oscar Friedensohn, New York State Commission for the Blind.

Dr. Milton D. Graham, director, bureau of research and statistics, American Foundation for the Blind.

Mrs. Mary Jane Hills, Empire State Association of the Blind.

George E. Keane, assistant executive director, the Industrial Home for the Blind.

Mrs. Elizabeth R. Locke, executive secretary, Syracuse Association of Workers for the Blind.

Charles McAllister, New York State Department of Mental Hygiene.

Miss M. Anne McGuire, director, New York State Commission for the Blind.

Miss Elizabeth Maloney, director of educational and social services, the Industrial Home for the Blind.

Miss Myra Morgan, president, Alumnae Association, New York State School for the Blind.

Mrs. Irene Rappaport, child psychologist, New York Association for the Blind.

Paul M. Ruhland, in care of New York State School for the Blind.

Dr. Herbert Rusalem, director of personnel service, Hunter College.

Miss Marian L. McVeigh, Office of Vocational Rehabilitation, Department of Health, Education and Welfare.

Paul C. Mitchell, New York Institute for the Education of the Blind.

Miss Sara Neufeld, Associated Blind, Inc.

Maurice D. Olsen, American Association of Instructors of the Blind.

Edward Ruch, Catholic Guild for the Blind, Diocese of Brooklyn.

Paul Sauerland, Catholic Guild for the Blind, New York diocese.

Irvin Schloss, legislative analyst, American Foundation for the Blind.

Dr. Dwight C. Smith, general secretary, John Milton Society.

Harry J. Spar, director of services, the Industrial Home for the Blind.

Fred R. Starcke, Parents of Blind Children of Long Island.

Mrs. Ada Kozier, Director of Children's Services, New York Guild for the Jewish Blind.

Miss Eleanor Walsh, assistant director, Bureau of Public Assistance, New York State Department of Social Welfare.

Rev. Alfred J. Weinlich, director, Catholic Guild for the Blind, Diocese of Brooklyn.

REPORT OF WORKSHOP ON REHABILITATION OF THE BLIND

Cochairmen : Dr. Peter J. Salmon, Dr. Eber L. Palmer

This report of the workshop on rehabilitation of the blind is presented to the Subcommittee on Special Education of the Committee on Education and Labor of the U.S. House of Representatives with considerable enthusiasm because of the fact that the group which deliberated on the matters contained in the report represented usually divergent opinions and interests in the field of work for the blind in New York State, and in addition, there were representatives from some of the national agencies in this field. Their enthusiasm reflects itself in the fact that there was a consensus on all points contained in the report by actual vote.

RE TITLE X OF THE SOCIAL SECURITY ACT

Problem 1

Condition of unemployable blind persons :

As the handicap of blindness is very frequently increased by factors of advanced age, poor health, secondary disabilities, and work background and aptitudes which cannot effectively be used without sight, many blind persons are unemployable and a major portion of these unemployable blind persons find that living with public assistance is a permanent way of life. In view of this, the subsistence provided by public assistance is inadequate to support wholesome morale in these blind recipients and, consequently, results in unhappiness for the recipients and deterioration of the social setting in which they live.

Under the present law, welfare agencies, as well as friends and relatives, who have no legal responsibility for these blind persons but who may be interested in ameliorating their condition are prevented from offering any regular financial assistance by the fact that any such assistance is nullified by an offsetting reduction in the public assistance grant.

Proposal

Title X of the Social Security Act should be amended to mandate the exclusion of a stipulated amount of income from any source—not restricted to earned income—in computing the resources of blind recipients of public assistance.

Problem 2

Condition of blind persons with marginal employability :

Blind recipients of public assistance who are capable of partial self-support are denied an adequate incentive to help themselves, as no portion of their earnings, beyond the meager limit of \$50 per month, can be used to improve their severely depressed standard of living under the present law. They are denied the values accrued from work, as the satisfaction that work can afford lies largely, for most underprivileged persons, in the tangible rewards of work. This condition tends to perpetuate the frustration of being unable to rise above a subsistence level of living. It produces a defeatism and loss of dignity for the blind persons involved which diminishes their abilities to contribute to the economic and social health of the communities in which they live.

Those blind persons who have been self-supporting prior to having to resort to public assistance and who have some potential for regaining self-support find that the rewards of their thrift and hard work are nullified by the requirement that they exhaust or assign all of their real estate holdings and their life insurance. This requirement tends to delay the acceptance of public assistance by impoverished blind persons who undermine their own health and deteriorate the social climate of the communities in which they live by their delay. It also, together with the prohibition against saving by recipients of public assistance, often imposes unsurmountable barriers to the reestablishment of self-support by blind recipients of public assistance.

Proposals

Title X of the Social Security Act should be amended to mandate that—

(a) one-half of the earned income of blind recipients of public assistance be excluded in computing their financial resources ;

(b) a stipulated amount of life insurance and real estate, up to a stipulated assessed evaluation, serving as a domicile for blind recipients of public assistance be excluded in computing their resources ;

(c) blind recipients of public assistance be permitted to retain in escrow earnings and other income in excess of the exempt resources proposed above

for use in the purchase of a business or in entering upon any occupation which may hold promise of providing them with a means of self-support.

Problem 3

Inadequate appreciation of the needs and potentialities of blind recipients of public assistance: Administrators of public assistance who are unable to devote an adequate portion of their time to studying the special needs and potentialities of blind persons fail to appreciate the difference between the unique conditions which affect blind recipients of public assistance and those which prevail for recipients of public assistance who are not blind and which form the basis upon which public assistance programs are developed and administered. This situation has resulted, generally, in the evaluation, on both the Federal and State levels, of public assistance administered to the blind by standard criteria of costs and results and, inevitably, such an evaluation fails to reveal the true condition of blind recipients of public assistance or to suggest the measures that are so desperately needed to alleviate their condition.

Proposals

It is suggested—

(a) that title X of the Social Security Act should be amended to provide at least one full-time consultant on services to the blind in the public assistance office of the U.S. Department of Health, Education, and Welfare;

(b) that the Bureau of Public Assistance should regularly collect and publish detailed statistics on recipients of aid to the blind.

Problem 4

Need for increased Federal participation in public assistance for the blind:

The increased costs that will be entailed in the proposed improvements in public assistance to the blind may be difficult for the States to absorb in their entirety. We feel that such increased costs, therefore, should be shared by the Federal and State Governments.

Proposal

Title X of the Social Security Act should be amended to provide a revised formula which will increase the per capita grant from the Federal Government to the States for public assistance to the blind.

RE TITLE II OF THE SOCIAL SECURITY ACT

Problem 5

Economic disadvantage of employed blind persons: The necessity of selecting a place of residence convenient to public transportation, the necessity of employing safe transportation facilities, the necessity of patronizing those stores that provide maximum assistance in purchasing, the necessity of employing painting and other property maintenance services, and a great many other conditions serve to impose an extraordinary burden of major consequence upon the financial resources of blind persons. This means that any blind person requires significantly greater financial resources than his seeing peer to maintain a given standard of living. In addition, with very few exceptions, a blind person's earning power is substantially lower than it would be if he could see or than it was before he became blind. Aside, therefore, from the relatively few fortunate blind persons who are able to earn a substantial income, any blind person in our society suffers a major economic disadvantage which tends to deny a basic sense of security. For these reasons and because the disability provisions of the old-age and survivors insurance section of the Social Security Act have related benefits to rehabilitation, to substantial gainful employment, to arbitrary age 50, and to a minimum definition of blindness, amendments are needed to resolve this sense of insecurity and to clarify the eligibility requirements for disability benefits under the act.

MINORITY VIEWPOINT

Mrs. Florence Starr wished to be recorded as being in disagreement with the problem as stated, although she was in favor of the proposal, because she believes that the problem as stated is not professionally based.

Proposals

Title II of the Social Security Act should be amended to provide—

(a) benefits as an absolute right regardless of age, income, or employment status, related exclusively to the establishment of the disability of blindness within the following definition: "Central visual acuity of 20/200 or less in the better eye with correcting lenses, or visual acuity greater than 20/200 if accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than twenty degrees."

(b) that the present requirement of coverage of 20 quarters of the last 40 quarters be reduced to no more than 1 quarter of coverage;

(c) that the present provision of compulsory acceptance of rehabilitation be abandoned, but that instead the OASI be encouraged to suggest rehabilitation to all beneficiaries.

Problem 6

Blind persons who earned coverage after onset of blindness: The field of work for the blind is aware of a very real problem concerned with blind persons who have been employed in covered industry during the course of their blindness and who have earned benefits which under the present law will not become available to them. We are also aware that a revision of the law which would make benefits available to such employed blind persons might, during the first period in which the law becomes effective, create a request from a relatively large number of blind persons for benefits hitherto not available to them. It is our belief, however, that in the overall plan of insurance benefits concerned with disability such a temporary increase in the numbers of those eligible for benefits would be negligible, and as a matter of human justice and for the welfare of the community as a whole, we propose:

Proposal

Title II of the Social Security Act should be amended to make disability insurance benefits available to persons who have earned coverage since the onset of the disability of blindness.

RE PUBLIC LAW 565

Problem 7

Condition of unemployable blind persons: Many blind persons who are unemployable impose an unnecessarily heavy burden on the time and energies of the individuals most directly concerned in their welfare because of the extremely limited opportunity available to such persons to receive training in skills of self-care.

Proposal

Public Law 565 should be amended to give the U.S. Department of Health, Education, and Welfare responsibility for providing rehabilitation appraisal and training services, through the appropriate State agencies, to blind persons who may be incapable of developing ability to engage in remunerative employment but who may show good potential for achieving, through proper training, ability to meet the requirements of basic independent living and to contribute to the maintenance of a wholesome, social, and emotional atmosphere in the setting in which they live.

Adequate legislation should be provided to assure the meeting of the recognized needs of independent living for a large group of our population, and the Department of Health, Education, and Welfare be charged with responsibility for so integrating its services that this result will be accomplished, and particularly, that the problems of the blind be given consideration so that they might through appropriate services gain the ability to achieve the highest level of independent living possible.

Problem 8

Inadequate understanding on the part of rehabilitation personnel who do not specialize in services to the blind of the special problems which result from blindness and the techniques of helping to meet these problems: The fact that blind persons comprise only a small portion of the handicapped persons served under Public Law 565 makes it impossible for administrative personnel re-

sponsible for the operation of the total Federal-State rehabilitation program to devote sufficient time to the special needs of blind persons to become adequately familiar with the best means of meeting their needs and helping them achieve their optimum potentialities.

Proposal

The U.S. Office of Vocational Rehabilitation should strengthen its services to the blind, and assign one full-time consultant on services to the blind to each of its regional offices.

Problem 9

Insufficient use and development of existing specialized services for the blind: The inability under present law of State rehabilitation agencies to delegate responsibility for rehabilitation counseling, placement, and certain other services results in an uneconomic duplication of public and private services and in an inability of State rehabilitation agencies to provide services in geographic areas in which private specialized services for the blind are nonexistent.

Proposal

Public Law 565 should be amended to permit State rehabilitation agencies for the blind to purchase any or all services on a per-case basis from agencies or other resources which operate programs that meet standards established by the State agencies and which will submit to case audits by the State agencies with the understanding that (1) failure on the part of an agency or resource to meet the standards established by the rehabilitation agency for the blind in its State will disqualify such agency or resource as a resource from which the State agency may purchase service; and (2) failure to follow procedures in any case for the providing, recording, and reporting of services will make the agency ineligible to receive payment for the services rendered in the case. These provisions would reduce the demands upon the State agencies for the providing of direct service in geographic areas where qualified agencies or other resources operate, would assure the rendering of unduplicated competent rehabilitation services to blind persons in the State, and would continue the opportunity of the agency or other resource to demonstrate and initiate, at its own expense, new or different techniques and procedures in serving blind persons.

MINORITY VIEWPOINT

Mrs. Mary Jane Hills: "It is our contention that placement and counseling should remain the responsibility of the Vocational Rehabilitation Service."

Problem 10

Insufficient availability of professional and technical personnel qualified to serve blind persons: Teaching grants to colleges and universities and traineeships for students are currently contributing to the preparation of rehabilitation counselors, specialists in physical medicine rehabilitation, and certain other professional personnel required to staff the expanding rehabilitation services throughout the United States. However, the support currently provided for the training of rehabilitation personnel is generally unavailable for the training in services to the blind of many professional and technical specialists important to the conduct of competent rehabilitation programs for blind persons, and the general lack of familiarity with specialized services for the blind on the part of college and university teaching personnel imposes severe limitations on the extent and quality of training which colleges and universities can provide in the field of service to the blind.

Proposal

Public Law 565 should be amended to provide (a) scholarships and fellowships for persons qualified in the various professional and technical specialties that operate in the field of service to the blind in order that such persons—psychologists, teachers, occupational therapists, etc., might receive the type of orientation and training that will equip them to practice their respective specialties in serving blind persons; and (b) field training grants to public and private agencies operating competent rehabilitation programs for the blind to be used to provide, in cooperation with appropriate teaching institutions, orientation and training to qualified professional and technical specialists whose services are needed in the rehabilitation of blind persons.

RE PUBLIC LAW 732 AS AMENDED

Problem 11

The Randolph-Sheppard law was originally set up as a means of providing one of the most meaningful opportunities for the employment of blind persons, and over the years has accomplished a great deal toward this end. However, during this time there has been increasing evidence of the encroachment of vending machines in buildings where the vending stand was or could be made adequate to provide for the occupants of the building. It is felt that pressures have been brought to bear on the officials in charge of the building resulting in making it difficult for blind persons to have the opportunities which Congress intended. There is no desire, however, on the part of those working with the blind to insist on stands being set up where a cafeteria is clearly indicated. The device of utilizing vending machines has in some instances been employed in order to divert income to purposes other than those authorized in the act.

Proposal

Public Law 732 should be amended so as to preclude the income from vending machines accruing to any group or purpose other than to the blind. Further, the installation of such vending machines should be limited to areas which are not feasible for vending stands. Provision should be made within the appropriate Federal agency to appeal from departmental decisions contradictory to the purposes and intent of the law.

RE HILL-BURTON ACT

Problem 12

Inadequate facilities for the providing of needed rehabilitation and special education services for blind persons.

Proposal

The Hill-Burton Act should be broadened to provide facilities and equipment, beyond those operated under medical auspices, essential to rehabilitation or special education programs for the blind—such as diagnostic and treatment centers for blind children and youth, rehabilitation centers for blind adults, special workshops for blind persons, nursing homes and special residences for aging and otherwise incapacitated blind persons, etc.

RE LIBRARY OF CONGRESS ACT

Problem 13

Inadequacy of existing facilities for the distribution of books and materials for blind persons. There exists a need for research in order to discover more adequate ways of improving books, materials, machines, and other devices for the use of the blind and to establish adequate means for their distribution.

Proposal

The Library of Congress Act should be expanded to provide funds to build and operate libraries and other facilities, or to support existing libraries or other facilities for the distribution and repair of books and special materials for blind persons, and to undertake to encourage technological research for the improvement of existing machines or other devices or the development of new devices.

RE CIVIL SERVICE ACT

Problem 14

Many blind persons are denied a fair opportunity to obtain employment under civil service because of preconceptions held by some Government personnel concerning the disabling effects of blindness.

Proposal

The Civil Service Act should be amended to provide that (a) no person otherwise eligible should be denied the right to compete in a civil service examination or to hold civil service employment on the basis of blindness alone; and (b) any blind person who may have reason to believe that he is barred from a particular civil service examination or a particular civil service position on the basis of his blindness alone may file an appeal and receive the benefit of arbitration of his claim of discrimination by an impartial board appointed by an appropriate officer in the Civil Service Commission and may have the option of being represented before this board by a rehabilitation specialist approved by the Division of Services for the Blind of the U.S. Office of Vocational Rehabilitation or by a person of his own choosing at the discretion of the aggrieved blind person.

RE INTERNAL REVENUE CODE, SECTION CONCERNED WITH EXEMPTION FROM PAYMENT
OF EXCISE TAXES

Problem 15

Burden placed on financial resources of nonprofit philanthropic agencies by their payment of excise taxes: The service programs of nonprofit philanthropic agencies are operated with the support of private voluntary contributions and/or Government support. The payment of excise taxes by such agencies tends to defeat both the purpose of the deduction from personal income of contributions to charitable organizations permitted in the payment of income taxes and the purpose of Government payments for the support of such organizations. The payment of excise taxes by nonprofit philanthropic agencies entails an expenditure for them of considerable proportions which has the effect of diminishing their capacity to serve their clients.

Proposal

The section concerned with the exemption from payment of excise taxes under the Internal Revenue Code, section 501(c)(3), should be broadened to exempt all agencies for the blind now or hereafter recognized and exempted as nonprofit charitable organizations.

RE RESEARCH

Problem 16

It is currently recognized that a minimum of research effort is being applied to the field of the rehabilitation of blind persons, and that in the past adequate funds have not been available to promote such research. Now that funds are available under Public Law 565 and other Federal laws, not a sufficient percentage of such funds is being spent in the areas of problems arising out of blindness. It is hoped that research applied in this field might have application throughout the whole area of rehabilitation.

Proposal

The U.S. Department of Health, Education, and Welfare should encourage collaborative research on the problems of blind adults involving medical, social and technological factors. Such research should be long term and full costs should be covered by grants-in-aid or by contracts.

THOSE WHO ATTENDED WORKSHOP REHABILITATION OF THE BLIND, OCTOBER 28, 1959

Dr. Peter J. Salmon, executive director, cochairman, the Industrial Home for the Blind.

Dr. Eber L. Palmer, superintendent, cochairman, New York State School for the Blind.

Mr. Herbert R. Brown, director, Vocational Rehabilitation Service for the Blind, Department of Social Welfare.

Mr. Anthony Cimino, guidance counselor, New York State School for the Blind.

Mr. Raymond J. Dinsmore, business manager, Blind Industrial Workers' Association of New York State.

Mrs. Mary K. DeWitt, managing director, Blind Work Association, Inc.

Mr. Oscar Friedensohn, assistant director, Commission for the Blind.

Dr. Milton D. Graham, director, Bureau of Research and Statistics, American Foundation for the Blind, Inc.

Mr. Jean C. Goehrig, sales manager, Industries for the Blind of New York State..

Miss Marion Held, director of service, New York Association for the Blind.

Mrs. Mary Jane Hills, president-elect, Empire State Association of the Blind.

Mr. George E. Keane, assistant director, the Industrial Home for the Blind.

Mr. C. C. Kleber, general manager, National Industries for the Blind, Inc.

Miss Elizabeth R. Locke, executive secretary, Syracuse Association of Workers for the Blind, Inc.

Miss Elizabeth Maloney, director of educational and social services, the Industrial Home for the Blind.

Miss Helen C. McBride, executive secretary, Central Association for the Blind.

Miss M. Anne McGuire, director, New York State Commission for the Blind.

Miss Marion L. McVeigh, Office of Vocational Rehabilitation, region II, Department of Health, Education, and Welfare.

Mr. Paul C. Mitchell, assistant principal, New York Institute for the Education of the Blind.

Miss Myra Morgan, president, Alumnae Association, Batavia School for the Blind.

Mr. Carl E. Olsen, manager, industrial division New York Association for the Blind.

Mr. Maurice Olsen, executive; secretary, American Association of Instructors of the Blind.

Mr. Paul M. Ruhland, principal, New York State School for the Blind.

Dr. Herbert Rusalem, Director of Student Personnel Services, Hunter College.

Mr. Paul Sauerland, Catholic Guild for the Blind for the Archdiocese of New York.

Mr. Irvin Schloss, legislative analyst, American Foundation for the Blind.

Mr. Irving M. Selis, executive director, Associated Blind, Inc.

Mr. Allan W. Sherman, executive director, New York Association for the Blind.

Mr. Dwight C. Smith, general secretary, John Milton Society.

Mr. Harry J. Spar, assistant director, the Industrial Home for the Blind.

Mr. John Taylor, executive director, National Federation of the Blind.

Miss M. Roberta Townsend, National Industries for the Blind, Inc.

Mr. Charles R. Wallendorf, director, Special Services School, Vocational Education and Extension Board, Nassau County.

Miss Eleanor Walsh, New York State Department of Social Welfare.

Mr. ELLIOTT. Our next report is that of the group for the emotionally disturbed. It is headed by Dr. Dave Salten, chairman, and Dr. Philip Wexler, cochairman.

Will Dr. Salten and Dr. Wexler please come forward.

STATEMENT OF DAVE SALTEN, COCHAIRMAN, WORKSHOP ON EMOTIONALLY DISTURBED

Mr. SALTEN. Dr. Wexler had to return to Albany. He expresses his regrets.

Mr. ELLIOTT. You may proceed, Dr. Salten. We are anxious to hear your recommendations.

Will you tell us were they reasonably unanimous? Did your workshop group reach the conclusions you are going to present to us in a reasonably unanimous fashion as was true with the blind?

Mr. SALTEN. The decision was entirely unanimous, Mr. Chairman. There was no minority report included.

Mr. ELLIOTT. You may proceed, Dr. Salten.

Mr. SALTEN. During the last 2 days, Mr. Chairman, a workshop of 25 experts from the fields of psychiatry, psychology, social work, special education, and vocational rehabilitation have met under the chairmanship of Mr. Philip Wexler and myself, to deal with the problem of education for the emotionally disturbed.

The specific recommendations of that group will be made available in several days.

I ask now, Mr. Chairman, for permission to submit that report to the committee within a few days.

Mr. ELLIOTT. I believe we said previously that the record would be open for 10 days. Is that sufficient?

Mr. SALTEN. That is entirely sufficient.

Mr. ELLIOTT. You may proceed with that understanding.

Mr. SALTEN. I ask now for 2 or 3 minutes to add to that report a short oral statement which, in our judgment, expresses the consensus of the meeting of the past 2 days.

All of us felt that it was a matter of national policy to use in the most productive fashion the talents and capabilities of all the people

of this Nation, the exceptional and handicapped as well as the normal. We felt that how America deals with its exceptional children is a prime indicator of its philosophy concerning individual human dignity and the welfare of our Nation.

We recognize how generous the Congress has been for many years in providing for national assistance to handicapped children and adults through the various statutes which make possible the Children's Bureau, the Office of Education, the Office of Vocational Rehabilitation, and the National Institutes of Health.

What we ask for today, Mr. Chairman, is a plea, a plea to the Congress, to include the emotionally disturbed children among the categories of the handicapped. We feel that the inclusion of this group in the categories of the handicapped, therefore making them available for various types of assistance now possible under the law, will be a great step forward in realizing the potential of all our citizens.

Our committee finds that the emotionally handicapped children of this Nation comprise the single largest group of exceptional pupils in our educational system.

We find also that extreme shortages exist in every area of specialization, teachers of the emotionally disturbed, psychologists, school social workers, and so on, and that on the national level, there is a manpower shortage in the educational field generally, but locally even where manpower is potentially available, training facilities are insufficient to meet the demand.

We find also that a great need for coordination exists at all levels, as evidenced by the fact that educators and mental health specialists are still going through a period of trial and error in determining the best means of meeting the needs of the emotionally handicapped, and although various Federal and State agencies have given financial support to different projects, it is vital that all experimental programs be properly evaluated.

We recommend, therefore, the creation of a commission under Federal auspices to study interrelationships between education and emotional disorders, such commission to undertake the evaluation of such pressing problems as:

- (1) Criteria for definition of emotionally handicapped children in terms of their children;
- (2) the extent of such emotionally handicapped conditions among children of school age;
- (3) an estimate of the loss due to emotional handicaps, and a survey of remedial measures within the schools as well as treatment facilities outside the schools which now serve emotionally disturbed children.

In its evaluation, this commission would cooperate with Federal and State agencies looking toward such economies as might be effected through the elimination of duplicated services, with this commission acting as a clearinghouse for the dissemination of information and research related to the area it has studied.

It would evaluate remedial measures, in some cases through support of private projects, encourage, facilitate and support such research as indicated and undertake whatever steps the commission would find

necessary in order to alleviate this national problem and to make recommendations as to its solution.

Mr. Chairman, that completes the report of our group on the emotionally disturbed.

Mr. ELLIOTT. Thank you very much.

Chairman BARDEN. The first thing I want to mention is, do not give all your thanks to Congress in providing these things. The thanks belong to the good people of America whose tax money pays for it.

We try to distribute it wisely, and sometimes I think we are pretty heavyhanded in the distribution. But in the final analysis, it is the people; and a lot of them are sitting in this room—their money went into whatever good we have done.

We were just privileged to associate ourselves with the program.

There is one thing that I would like for you to do in filing your statement. That is, provide the best possible definition of what you mean by "emotionally disturbed."

I taught school at one time, and at one time it was very difficult for me to tell whether my students were emotionally disturbed, or whether it was myself. I would like that to be in very definite terms for the assistance of the committee.

Mr. SALTEN. May I respond to that?

Chairman BARDEN. Yes, sir.

Mr. SALTEN. I want to thank you, Mr. Barden, for your very gracious remarks concerning American taxpayers. But the committee did want me to express the fact that we felt the committees of the Congress had been not simply generous, but farsighted in their provision of needed funds for this important segment of our population.

Concerning the matter of definition, Mr. Barden, I say that the question of definition and incidence concerned the committee during the first 6 hours of its deliberation, and we decided at that point to move on to other matters.

It is recognized that in the case of the blind, the deaf, the orthopedically handicapped, and the like, the problem of definition is relatively simple.

Chairman BARDEN. I just have to comment that passing the buck is not a new custom.

Mr. SALTEN. We shall not pass the buck to the Congress, Mr. Barden. We hope to provide some information which will enable the members of your committee to give us some genuine assistance.

Chairman BARDEN. It is important because I have been through that before, and you educated people just give me more trouble with these big combinations of words; but you never give me much light on the detailed definition. That is why I have been two or three times suggesting that when the term is used, the definition is terrifically important.

Thank you. I apologize for interrupting you, but if you will put that into the record, I, for one, will appreciate it.

Mr. SALTEN. We will attempt to do that with the greatest clarity possible.

Mr. ELLIOTT. Thank you, Doctor.

Mr. SALTEN. Thank you.

(The material referred to follows:)

REPORT OF SUBCOMMITTEE ON SPECIAL EDUCATION OF THE EMOTIONALLY DISTURBED.
HUNTER COLLEGE, OCTOBER 27-28, 1959

Cochairmen: Dr. David G. Salten, superintendent of schools, Long Beach, N.Y.,
Dr. Philip Wexler, department of mental hygiene, Albany, N.Y.

PREFACE

With the presentation of these findings, will be a number of recommendations dealing specifically with the unmet needs of a substantial proportion of the Nation's population presently categorized as subgroups of the exceptional. Each of the workshop committees will point up needs for additional personnel, research, and services.

In many instances, these needs as stated by the many subgroups will seem similar; however, in the area of the emotionally disturbed, much must be accomplished in order to achieve even parity with many of the other handicaps.

The stigma attached to emotional disabilities in the past has effectively limited the organization and growth of large active groups such as those operating on behalf of many of the other handicaps. This in part explains the phenomena that Federal legislation and the financial aid derived therefrom for the emotionally disturbed has admittedly lagged behind similar legislation in other areas of the handicapped.

Statistically, the emotionally handicapped children comprise the single largest group of exceptional pupils in our educational systems. This fact might indicate the need for some revolutionary changes in Federal legislation to meet the needs of this large handicapped group. In actuality, the findings of the workshop on the emotionally disturbed and the proposals we feel are merely evolutionary to the level of acceptance of all other handicaps.

I. THE PROBLEM OF THE DEFINITION OF THE EMOTIONALLY DISTURBED

Most handicaps which are readily defined are the result of a defect easily recognizable to the eye or to existing measurement techniques, either physically, intellectually, or neurologically.

(a) *General definitions*

A general definition of the emotionally disturbed may be one that merely describes the individual as one lacking good mental health. The term "good mental health" is diffuse in meaning but generally applies to:

- (1) Adequate personal strength to meet the trials and tribulations of living with responses that are acceptable to the social mores of the community at large.
- (2) A knowledge and appreciation of limitations equally balanced by a satisfying and productive use of capacities.
- (3) Social adjustment that does not bring conflict with peers or authority.

If these be acceptable, then the emotionally disturbed can be said to be those who live in a chronic state of poor mental health.

(b) *Proposed definition for use in determining Federal legislation*

The Dictionary of Education, second edition, McGraw-Hill, 1959, defines the "handicapped child," as "a child whose physical, mental, emotional, educational, or social condition places him at a disadvantage in comparison with normal children."

It then describes "the emotionally maladjusted child" as "(1) a child whose behavior is so different that he cannot participate in normal activities with other children; (2) a child who cannot benefit from the school situation because of deep psychological problems that bring about deviant behavior and resistance to learning, development, and growth."

It still further describes "the emotionally disturbed child" as one "with a deep-rooted problem who habitually expresses his feeling in a deviant manner."

This definition could be augmented by five characteristics of the emotionally disturbed child as cited by Dr. Eli M. Bauer, State Department of Education, Sacramento, Calif., who has done research in this field:

"(1) An inability to learn which cannot be explained by intellectual, sensory, or health factor.

"(2) An inability to build or maintain satisfactory interpersonal relationships with peers or teachers (adults).

"(3) The appropriate types of behavior or feelings under normal conditions.

"(4) A general pervasive mood of unhappiness or depression.

"(5) A tendency to develop illnesses, pains, or fears associated with personal or school problems."

In general, an emotionally disturbed child is one whose mental health processes are impaired, preventing him from gaining from or maintaining himself in school or life settings.

II. UNMET NEEDS

(1) Perhaps the greatest unmet need in terms of Federal legislation is the recognition of this type of handicap and its existence. There are, under the four major Federal bureaus dealing with the handicapped (Office of Vocational Rehabilitation, Children's Bureau, Office of Education, and National Institutes of Health), legislative actions that could aid in helping meet the needs of this type of child. The implication that these acts are to include this type of handicap can be accomplished by a highlighting of its existence by this congressional committee.

(2) Shortages exist in every area of specialization; teachers of emotionally disturbed, psychological staff, social workers, and all of the other professional disciplines involved in meeting the needs of those emotionally disturbed children (rehabilitation, nursing, etc.).

(3) Training facilities and training grants are insufficient if not nearly non-existent to meet the ever-growing demand for specialists in the area of the emotionally disturbed.

(4) A need for coordination exists at all levels as evidenced by the fact that educators and mental health specialists are still going through a necessary period of trial and error in determining the best means of meeting the needs of the emotionally handicapped; and, although various Federal and State agencies have given financial support to different projects, it is vital that all experimental programs be properly evaluated.

(5) There is a need for a comprehensive survey and evaluation of present educational and remedial measures within the schools, as well as treatment facilities outside the schools, which now serve emotionally disturbed children.

III. PROPOSALS

(1) Under the extension and improvement section of Public Law 565, grants-in-aid to provide rehabilitation facilities are set up and should be expanded to include moneys and programs for the emotionally disturbed. This could be accomplished by setting up within the Office of Vocational Rehabilitation structure consultative positions to assist the States and local communities in planning such services.

(2) Under the Children's Bureau Act, grants-in-aid to States are provided for services for maternal and child health services which include counseling and clinical services for both parents and children defined as retarded. These grants-in-aid should be expanded to include the emotionally disturbed child and make available the establishment of large clinics in urban areas and traveling clinics for rural areas.

(3) Public Law 482, the Medical Facilities Service and Construction Act, provides for construction of rehabilitation centers and facilities and should be expanded in definition to include the emotionally disturbed (handicapped).

(4) The research training grant program of the National Institutes of Health (Mental Health and Neurological Disease) provides funds for fellowships, scholarships, and research grants which could be expanded to include programs for the emotionally disturbed.

(5) The cooperative research program of the Office of Education should be allocated additional funds to include plans for programs for the emotionally disturbed.

(6) Under the titles of the Social Security Act an interdisciplinary approach representing health, education, and welfare should be established as a referral unit in disseminating information to all public and private:

- (a) Health organizations;
- (b) Social welfare agencies;
- (c) Schools;
- (d) Clinics;

as a means of developing an awareness in these agencies of the necessity for early identification and evaluation of emotional disturbance.

(7) The staffs of the Office of Vocational Rehabilitation, National Institutes of Health, Office of Education, and Children's Bureau should be expanded with specialists in the area of emotionally disturbed to render field consultation services throughout the country.

(8) Provisions should be made for strengthening of the interagency approach which is inherent in the coordinated workings of the units of the Department of Health, Education, and Welfare to establish joint research projects and training grants to meet the needs regarding limited personnel.

(9) Federal acts and organizations that affect aid to the handicapped should be studied with an eye to expanding facilities and training of personnel for all disciplines involved in working with the emotionally disturbed.

IV. CONCLUSION

The expending of funds to fulfill or even partially fulfill the requirements under the few proposals as listed herein will in actuality result in a savings of the tax dollar in the future through proper inclusion of the emotionally disturbed under all of the existing Federal legislation and recommended procedures. The savings will be readily evidenced by the number of individuals who could through proper services and good mental hygiene approach be not only maintained in their communities, but also become contributing members to the society in which they live.

ATTENDANCE SHEET, WORKSHOP IN SPECIAL EDUCATION AND REHABILITATION

Emotionally disturbed

Dr. David G. Salten, Dr. Philip Wexler, cochairmen

Herbert F. Johnson, superintendent of schools.

Kenneth M. Wilson, superintendent of schools.

Anthony S. DeSimone, assistant regional representative, Office of Vocational Rehabilitation.

Joseph Palevsky, Counselor, Office of Vocational Rehabilitation.

Bernard Schwartzberg, administrative director.

Margaret Lawrence, Rockland City Mental Health Board.

Dr. George M. Krupp, child psychiatrist.

Dr. M. H. Fouracre, head, department of special education.

Katherine D'Evelyn, director of psychological service.

Fern Charlton, supervisor of special education.

Dr. Mary Alice White, director, psychology department.

Barnet Rabinow, program director.

Ruth Schwartz, psychiatric social worker, Nassau Center, emotionally disturbed.

Dr. Laurette Bender, principal resident scientist, New York State Department of Mental Hygiene.

Dr. Carl Fenichel, director, League School.

Dr. Morris Krugman, assistant superintendent in charge, educational and vocational guidance.

Dr. Jean Thompson, Bureau of Child Guidance, Board of Education, New York City.

Dr. Gilbert Trachtman, research coordinator, Long Beach Schools.

Dr. Milton Kaufman, Director, Nassau Center, emotionally disturbed.

Dr. Harry Gilbert, Board of Examiners, Board of Education, New York City.

Dr. Herbert Turkel, New York University.

Dr. Victor B. Elkin, director of psychological services, Long Beach Schools.

Dr. Albert J. Harris, director, education clinic and program of education.

Bernard Soper, director psychiatric services, New York State Department of Mental Hygiene.

Dr. E. Goldsmith, vice president, Nassau Center, emotionally disturbed.

Dr. E. R. Clardy, director, child guidance, Rockland State Hospital.

Rev. David G. Farley, assistant superintendent, diocese of R.V.C.

Charles Wallendorf, vocational education and extension board.

Mr. ELLIOTT. Our next workshop group dealt with the problems of the gifted, and that group was headed by Mrs. Coutant, and the co-chairman was Dr. Meister.

Mrs. COUTANT. May I introduce Dr. Gardner, representing the New York State Teachers Association.

STATEMENT OF MRS. M. COUTANT, COCHAIRMAN, WORKSHOP ON THE GIFTED

Mrs. COUTANT. In your hands you have our little document that is the work from sweat and tears for the last 2 days. As Dr. Framton very properly stated, we did work into the late hours and we apologize for lack of finish.

I would like to talk to you in terms of what I see as highlights that are probably of the most interest to you. First of all, you are concerned as representatives of the people, naturally, with what the people think. The first thing I would like to say to you, and I think we have evidence to support it, is that there is a rapidly growing concern for the education of the gifted. There can be shown by the number of requests flooding our offices.

By offices, I mean the New York State Teachers Association, the State education department, the liaison, which I happen to be, for the American Association for Gifted Children.

We cannot keep up with the requests that come into us.

I would like you to know also that the community pressure is ahead of the administrators, many times, and I hope they don't take offense at it, but it is true that the public is pushing us, the parents and groups and the children themselves.

I can go on endlessly with quotes from the children, about it is exciting to learn that through learning is fun. They are delighted to go on.

So the community pressure, the demands of the students, and the requests coming in, plus the fact that 80,000 teachers believe essentially what we are telling you today, I think is good evidence.

You asked the other testifiers about the unanimity of the workshop we have just finished. I can say that they were really completely unanimous in their approval of the needs that we have suggested to you here.

This means a little more when I tell you that the workshop was made up of representatives from all parts of the State geographically.

We took nine viewpoints. We took world life, urban life, elementary, secondary, and higher education, teaching, guidance, administration, and research, and we took all of these angles and then integrated them.

We were amazed to find the unanimity of opinion when we got the recommendations together. We want to thank you for including the gifted in the concern of your subcommittee. We are very happy to be considered by you.

As we look at the whole problem of the gifted, I think it is important to see that we are dealing essentially with individual differences, and the rest of these people here have a little older history in this than we do. It goes back to the insane in England, when they used to have them in cages for the entertainment of the public on Sundays, and they would go out and tantalize these people in order to entertain themselves.

Now as we see it, all of these gaps are being filled by the people who are interested in the blind, the physically handicapped, and we rather latecomers are concerned about these youngsters who have real special abilities.

Rather than being 20 years late, Mr. Barden, I feel that our problem has been, among the people who came to this workshop, at least, that they may have been at least as much as 20 years ahead. It has been very hard to interpret this message to the public and bring them along with the leaders in the field.

We want to say essentially that the legislation you already have seems phenomenally good to us. We are most appreciative of the National Defense Education Act and the National Science Academy.

If you did nothing more than aid and abet the lines which you are already following, I feel that we in the gifted would be very happy with it. You have precedents for most of our recommendations, and you will see others, because we are not experts at legislation, by analogy, which will come from the rise of vocational education, by following the Smith-Hughes Act through the various George-Barden Acts, and so forth, and the services to agriculture. By analogy, I am sure you will come up with more ways that you could serve these gifted children than we could possibly devise.

We want to applaud the fact that you are having a workshop, as our representatives from the blind have already told you. If this does not influence your legislation in the least, the interplay among us was most valuable and we will consider the 2 days a terrific privilege.

We came up with our great needs. Need No. 1, as everyone else is telling you, is trained personnel. I cannot emphasize this too much. You will find that it is the first in our list, from what the people said.

The learning is the heart of the school, and learning varies with the teacher. Investment in teachers of quality can never be a mistake. That is the first point.

Second was research. We simply do not know what we are doing in many instances, and we will not know unless we devise much more adequate research than we now have.

Third, we need suitably challenging programs for these youngsters. Once they become accustomed to challenged programs, they are no longer satisfied with what we have been giving them in the way of school fare in the past.

The fourth and last of our imperative needs, I will not bore you with many other little needs, is administrative structure. We do need help through established channels and expansion of channels that you already have.

The recommendations you will see on your papers that we have devised to explain, we hope that they might help you in solving the case.

However, we now enter your territory where you know best how to make the legislation. All I can say is that general legislation that can be interpreted to provide opportunities for gifted is probably preferable to our group than specific legislation aimed at the gifted.

We would rather have your legislation broad in vision so that we can interpret it to our needs, and then let the local and State divisions

define or give the definitions and define the programs developed within this broad outline that you devise.

We have said very little about costs, as you can see, because we really don't know much about it. We have figured out in our experimental programs that if we can get at a per capita cost for any program that we have, we can compare this with the per capita cost of something else, anything in New York State.

For instance, our average central school has \$927 per student, and if we can divide that by months we come up with \$92.70 per month for 10 months.

Consequently, any program we devise, if it runs around \$90 a month, we feel we are within what the public is used to paying. So we do it in that way.

If we get more than that, we say perhaps we can still continue, but we want to economize a little.

In conclusion, we want to make available to you a collection of the most valuable documents that we have for your study and your committee's study. We want you to know that we are all glad to appear any time, and, as you can tell from me, at any length, at your request.

The most important thing perhaps I have heard about the gifted in the many years I have been at it is that gifted children can return to us more than we can possibly give to them. Their handicaps lie within us who are not so gifted, and guilty of adult delinquency. Please keep them in mind as you provide for all children.

Thank you very much.

Mr. ELLIOTT. Thank you very much, Mrs. Coutant. That was a very fine report. Does that complete the report?

Mrs. COUTANT. This is all we would like to say orally. We would like to have you read, of course, and we would love to have questions, if you have the time.

Mr. ELLIOTT. It is 10 minutes until 4 o'clock and we have five other groups to hear. So I think if I can urge my fellow committee members to forgo the questions, we will pass to the next group.

Thank you, Mrs. Coutant.

(The formal statement submitted by Mrs. Coutant follows:)

SPECIAL EDUCATION AND REHABILITATION STUDY, NEW YORK STATE WORKSHOP ON THE GIFTED, OCTOBER 27 AND 28, 1959, HUNTER COLLEGE, NEW YORK

Chairman: Madeleine F. Coutant, coordinator of programs for the gifted, director of the summer and winter program of advanced studies, elected representative of this workshop to report to the subcommittee hearings, October 29, 1959, board of cooperative educational services, first supervisory district, Oneida County

Cochairman: Morris Meister, president, Bronx Community College

It was with a general feeling of strong concern over the needs of the gifted children in our schools that the members of this workshop gathered to discuss these needs and what could be done to meet them. We are increasingly aware that children differ from each other and children with special abilities or "gifts" have special needs. We are now very concerned with developing our human resources as well as our natural ones. Our society, our Nation, is beginning to recognize its dependence upon the gifted in our society to assure its growth, security, and the care of its less fortunate members.

Because of this concern top professional educators came gladly to the workshop at their own expense from all parts of the State and almost every type and

level of education to work together for 2 full days to determine what the needs of our gifted are and how these needs could be met in a practical way. We know that in all the Federal and State legislation now affecting education there are few legal provisions that specifically allocate responsibility and funds for the education of the gifted. We approached the problem from nine viewpoints: rural life and urban life; elementary and secondary schools and higher education; teaching, guidance, administration, and research.

We found almost complete agreement on the needs of the gifted and on the belief that the Federal Government has a share in the responsibility for fulfilling these needs.

This morning, Dr. Cyril Wilcock, another representative of the workshop, described the past and present accomplishments in New York State. It is surely a fine record but we still have a number of urgent needs. Some of them you have already recognized and provided for in the National Defense Education Act: loans to students in institutions of higher education, a program for the identification and encouragement of able students, equipment, and supplies for science, mathematics, and foreign languages. We want you to know that the education profession appreciates the great strides made already through this act. We are watching results with great interest and wish to encourage you to expand your efforts through further legislation along similar lines.

The most imperative needs as seen by this workshop are four as listed below and accompanied by the recommendations which would meet these needs.

Need No. 1: Professional personnel, teachers, administrators, psychologists, curriculum specialists, counselors, and other professional personnel who know how to discover the special abilities of children and how to teach these children to do their best and make the most of their abilities. There is a shortage of teachers in general and specially of those with successful experience in handling gifted children.

We believe three ways to help solve this situation are—

(a) To provide ways for the teachers of gifted children to grow in general knowledge and in their special fields.

(I) Recommend Federal support for teacher education programs established in sufficient numbers in humanities, social studies, and the arts as an extension of the plan of the National Science Foundation in mathematics, science, and foreign languages. These programs should include both summer institutes and full year institutes and summer schools for gifted students that also serve as demonstration schools in which teachers can observe and participate.

(II) Recommend that a program be established to reimburse outstanding teachers to enable them to return to a university campus for 1 year to improve their command of their specialty.

(b) To recruit more and better students for special training as teachers of the gifted especially for the elementary schools.

(I) Recommend Federal grants-in-aid for the college preparation of educators for the gifted.

(c) To aid specially trained personnel for new kinds of services, including consultation, coordination, educational research. We have reached the stage in education where we need specialists to augment the classroom teachers as medical specialists augment its services of the general physician and diagnostician.

(I) Recommend that Federal funds be used to supplement local funds for the salaries of specialists in the education of the gifted as has been done for teachers of agriculture and home economics.

Need No. 2: Research to evaluate procedures already developed and to develop better ones; qualified personnel to conduct the research.

(I) Recommend a generous portion of all funds allocated for the gifted be unrestricted funds devoted to research in the area of the gifted; that the provisions of the legislation be modeled after the very efficient cooperative research program of the U.S. Office of Education which does not require matching funds either by State or local communities. Another essentially similar program which could serve as a model in title VII of the National Defense Education Act.

(II) Recommend that research funds be available for definitive evaluation of projects already in existence and well established as well as for new experimental program.

(III) Recommended a program of grants, scholarships, and fellowships to be set up to recruit and train personnel in the field of educational research and to provide training facilities for the program.

(IV) Recommended the strengthening of existing facilities whereby small communities can obtain consultation and supervision of educational research through their State department of education or nearby colleges and universities.

(V) Recommend that direct grants be made available to colleges and universities to facilitate and strengthen research in the area of the gifted.

Need No. 3: Programs to serve the gifted. Money and effort are increasingly directed to the discovery of gifted children at as early an age as possible but the programs for serving the children once they are selected are equally important. There is great need to develop appropriate courses and challenging activities.

(I) Recommend that the Federal Government supply grants for the experimental school initiation programs designed to serve the needs of the gifted.

(II) Recommend the extension of the National Defense Education Act provisions for identification of able students to the pupils of the elementary school.

(III) Recommend the continuation of the National Science Foundation research participation programs and the establishment of other similar national agencies for all the culturally productive arts so all potentially able students may begin to associate at an early age with professionally trained workers.

Need No. 4: Administrative structure to meet the needs of the rapid increase in the number of persons and projects involved in the education of gifted children.

(I) Recommend the expansion of the offices and facilities of the U.S. Office of Education.

(a) To include a clearinghouse to receive and disseminate information about programs for the gifted to both professional and lay groups—a pooling of resources of the Federal, State, and local levels.

(b) To assume a strong leadership role in the field of the gifted.

(c) To publish small inexpensive pamphlets that interpret to the public the importance of educating the gifted and making appropriate provisions for them.

(II) Recommend that the Federal Government match State funds in setting up local and regional offices of coordination for programs for the gifted to include sufficient staffing with coordinators, researchers, psychologists, etc.

COSTS

Most of the attention to the problems of the gifted has begun only in recent years. It is such a new field that we have not accumulated much experience with costs. Also due to the lack of communication among experimenters we have not been able to profit by the experience of others. Consequently, it is difficult for us to arrive at estimates of the costs of our various recommendations. In our own situations, we are using various methods. Probably, most schools tailor their programs to whatever amount of money is available. When the amount of money is not a limiting factor as in the case of special grants an effort is made to stay somewhere near comparable per capita costs. This means in New York State that we keep in mind the State aid per pupil, for example, about 927 in the small central schools including State aid of \$412 for high school students and \$330 for elementary pupils. For highly specialized services for the gifted, we may use \$700 per pupil for severely retarded children as a yardstick. Dividing the average amount by 10, we get a cost per month of \$92.70. In this way we judge the cost of \$91.75 per student for a 2-month summer school of advanced studies as being extremely reasonable as in one experience we have had in Oneida County.

On a national scale you might use this per capita cost and multiply it by the number of gifted children. Of the 36 million children in the country, we feel that 15 percent can be classified as gifted and talented, the percent changing according to the particular definition of "gifted," and the criteria for selection in any particular project. This type of calculation would indicate that approximately \$50 million would provide a complete 2 month special summer instruction annually for every gifted student. Of course, projects that require only a few

hours of instruction each day or week during the winter session can be prorated accordingly.

CONCLUSION

We appreciate fully the measures you have already enacted and we urge that you keep in mind the needs of the gifted and talented children as you view the needs of all children, expand the present good legislation and create new legislation as it seems possible and desirable.

Mr. ELLIOTT. The next group is the one that studied mental retardation.

Dr. Ignacy Goldberg, I believe, will present the findings of that group, and perhaps will be accompanied by Prof. Chris DeProsopo of that group.

STATEMENT OF IGNACY GOLDBERG, COCHAIRMAN, WORKSHOP ON MENTAL RETARDATION

Mr. GOLDBERG. The group considering the mentally retarded consisted of 28 individuals, representing colleges and universities, public schools, government agencies, private organizations, and we also had in our group a number of graduate students from Teachers College, Columbia University, the Special Education Department, who are the recipients of scholarships and fellowships under Public Law 85-926.

The group classified the unmet needs in the area of the mentally retarded under three broad categories:

- (1) Identification, evaluation, and health problems;
- (2) Special services and programs; and
- (3) Research and personnel.

Under identification, evaluation, and health, in an attempt to develop the broadest community approach to the early identification of the mentally retarded, the group recognized the necessity for promoting early identification of all exceptional children.

We feel that this can be best accomplished by developing an awareness of this need on the part of the following agencies:

- (1) Private and public health organizations;
- (2) Public and private social welfare agencies; and
- (3) Public and private schools.

The group recommends the establishment under title V of the Social Security Act of a referral unit within each State with a staff representing health, education, and welfare, who shall have the responsibility for establishing and maintaining continuous contact with all organizations in the above fields in order to—

- (1) Alert organizations to the problems of the mentally retarded;
- (2) To establish a central file of referral cases;
- (3) To disseminate this information to proper agencies for following up with due regard to protecting identity of individuals.

The group recommends allocation of funds under title V of the Social Security Act to the Children's Bureau, for expansion of present mentally retardation clinics, to include the increase in number of such clinics.

Two, development of traveling clinics in sparsely populated areas.

Three, allocation of funds for training of visiting health personnel to be attached to the clinics who would have the responsibility for assisting parents in home care and training of the children.

Under the grouping "Special services and problems," as unmet needs, the group states that funds under maternal and child health services and the crippled children services, are intended, as we understood, by the Federal Government to be used for the mentally retarded as well as other individuals with handicaps.

A problem was brought up that frequently the State agency receiving and administering such a fund is not charged by the State with the responsibility for the mentally retarded.

For example, the State health department receives and administers funds; however, the department of mental hygiene might be the responsible State agency for the program for the retarded, except for education of the retarded.

Therefore, the group proposes that all State plans, regardless of which State agency administers the funds, should be required to include a plan for the use of the funds for the mentally retarded as well as others.

Another proposal is that more Federal funds be made available under provision of the extension and improvement sections of Public Law 565, whether State surveys show the need for more sheltered workshops or rehabilitation facilities.

These funds should be tied into needs and available State and private funds within the States and not according to the formula by population.

Another proposal is: The Federal Government has spent millions of dollars to help establish sheltered workshops and rehabilitation facilities. These services have proved their value in terms of persons rehabilitated, resulting in savings to taxpayers by maintaining them in the communities.

The problem is that the Federal grants are limited as to time, and there is a great danger that these services will be curtailed or cease to exist when the grants expire.

Therefore, the group proposes that the House committee highlight the desirability that the States provide regular grants-in-aid for the continuing operation of the workshops or rehabilitation facilities which have met desirable standards.

The Office of Vocational Rehabilitation should be provided with funds to set up consultant positions to assist the States and communities in planning such services.

Another proposal: The concept of rehabilitation facilities in the independent living bill should be expanded to include a center which would help individuals to learn to care for themselves as much as possible, to utilize their innate capacities to a maximum degree so as to require a minimum of help from the other members of the family in daily living, and to be brought together for social and occupation activities in meaningful use for their days.

The last group of unmet needs comes under research and education. The group agrees that research should be carried out within the framework of the four Federal agencies now having the major responsibility for special education and rehabilitation programs.

These four agencies are: (1) The Office of Education, (2) the Office of Vocational Rehabilitation, (3) the National Institute of Mental Health, and (4) the Children's Bureau.

The group would like to go on record to commend the Congress for its interest in legislation and in the appropriation of funds by means of which a program has been begun in research and personnel training in the area of mental retardation. The studies completed and in progress indicate the complexity of the problem and the need for additional research of a comprehensive and long-range nature to amplify and follow through on the present findings which have served as a framework for future productivity investigations.

Research in other areas of mental retardation is also needed to form a complete picture of the problem at the various chronological and mental age levels.

The group considered recommendations under the various Government agencies: First, under the Office of Education, support of research should be broadened to include investigation of many complex problems of mental retardation. For example, there is a need for funds to support the development of new diagnostic instruments.

Second, research is needed in the area of long-range studies in learning processes of mentally retarded, et cetera.

A single comprehensive study was mentioned as an example to point out the interrelationships among the following factors:

(a) The location of the mentally retarded at the preschool level.

(b) Changes in intellectual status during the school years; and

(c) Absorption of the mentally retarded adult into the community.

Under the Office of Vocational Rehabilitation, the group felt that research in rehabilitation at an international level should be brought to the attention of American professional workers. Staffs should be strengthened to achieve these ends in order to coordinate, assimilate, and interpret these studies. The group agreed that the utilization of knowledge of international developments in special education should be an important aspect of all provisions for exceptional children and adults.

There is also a need to implement the findings of existing studies concerned with the factors involved in the educational adjustments of the mentally retarded.

Another recommendation was made that funds be provided for additional training of vocational rehabilitation counselors in the problems of mental retardation, and additional in-service training institutes be sponsored for this purpose.

As far as the National Institute of Mental Health is concerned, the group recognized that research in mental retardation cuts across many biological and sociological distances.

For example, it was recommended that sociological and psychiatric workers' studies be studied, particularly in the behavior sciences, to include investigation into family, community, and environmental effects on the mentally retarded.

Another recommendation was that personnel trainingship should be extended in areas auxiliary to education and rehabilitation of the mentally retarded in order to encourage trainees to undertake studies of special problems and needs in mental retardation.

Finally, some of the general recommendations were that there is a need to strengthen the interagency committee on mental retardation

on the Federal level, to coordinate the work of the units within the Department of Health, Education, and Welfare. For example, it was recommended that the services of the Office of Education and the Office of Vocational Rehabilitation be coordinated in order to facilitate the handling of certain needs of the mentally retarded in areas of education and rehabilitation, these needs being too extensive to be met by either agency alone. Demonstration of vocational and educational projects of a joint nature were suggested, as were demonstrations of comprehensive community centers for vocational training.

Thank you.

Mr. ELLIOTT. If there is any part of your statement that you did not read, be sure and give it to the reporter for the record.

Mr. GOLDBERG. Thank you, sir.

(Report submitted by Mr. Goldberg follows:)

MENTAL RETARDATION

Cochairmen : Chris J. De Prospro and Ignacy Goldberg

I. IDENTIFICATION, EVALUATION, AND HEALTH

In an attempt to develop the broadest community approach to the early identification of the mentally retarded, we recognize the necessity for promoting early identification of all exceptional children. We feel that this can be best accomplished by developing an awareness of this need on the part of the following agencies :

- (1) Medicine (private and public), health organizations.
- (2) Public and private social welfare agencies.
- (3) Public and private schools.

We recommend the establishment under title 5 of the Social Security Act of a referral unit within each State with an interdisciplinary staff (representing health, education, and welfare) who shall have the responsibility for establishing and maintaining continuous contact with all organizations in the above fields in order to—

- (1) alert organizations to the problems;
- (2) establish a central file of referred cases; and
- (3) disseminate this information to proper agency for following up with due regard to protecting identity of individuals.

We recommend allocation of funds under title 5 of the Social Security Act to Children's Bureau for expansion of present mental retardation clinics :

- (1) Increase in number of such clinics.
- (2) Development of traveling clinics in sparsely populated areas.
- (3) Allocation of funds for training of visiting health personnel to be attached to the clinics who would have the responsibility for assisting parents in home care and training of the children.

II. SPECIAL SERVICES AND PROGRAMS

Statement

Funds under maternal and child health services and the crippled children services are intended by the Federal Government to be used for the mentally retarded as well as other handicaps.

Problem

Frequently the State agency receiving and administering the funds is not charged by the State with the responsibility for the mentally retarded. For example, the New York State Health Department receives and administers funds; it claims that the department of mental hygiene is responsible for the retarded except for education.

Proposal

All State plans, regardless of who administers the funds, should be required to include a plan for the use of the funds for the mentally retarded as well as others.

Problem

Questions raised regarding the Elliott bill.

- (1) Are we in favor of this?
- (2) How far do we want to go in liberalization of this bill?

Proposal

More Federal funds be made available under provision of the extension and improvement sections of Public Law 565 where State surveys show the need for more sheltered workshops or rehabilitation facilities. These funds should be tied in to needs and available State and private funds within the States and not according to the formula by population.

Statement

Federal Government has spent millions of dollars to help establish sheltered workshops and rehabilitation facilities. These services have proved their value in terms of persons rehabilitated resulting in savings to taxpayers by maintaining them in the community.

Problem

That the Federal grants are limited as to time and there is a grave danger that these services will be curtailed or cease to exist when the grants expire.

Proposal

That the House committee highlight the desirability that the States provide regular grants-in-aid for the continuing operation of the workshops or rehabilitation facilities which have met desirable standards. The Office of Vocational Rehabilitation should be provided with funds to set up consultant positions to assist the States and communities in planning such services.

The concept of rehabilitation facilities in the independent living bill should be expanded to include a "center" which would help individuals to learn to care for themselves as much as possible, to utilize their innate capacities to a maximum degree, to require a minimum or no help from other members of the family in daily living, and be brought together for social and occupational activities and meaningful use of their day.

III. RESEARCH AND PERSONNEL TRAINING

The group agreed that research should be carried out within the framework of the four Federal agencies now having the major responsibility for special education and rehabilitation programs. These four agencies are:

- (a) Office of Education.
- (b) Office of Vocational Rehabilitation.
- (c) National Institute of Mental Health.
- (d) Children's Bureau.

Congress is to be commended for its interest in legislation and in the appropriation of funds, by means of which a program has been begun in research and personnel training in the area of mental retardation. The studies completed and in progress indicate the complexity of the problem and the need for additional research of a comprehensive and long-range nature to amplify and follow through on the present finding which have served as a framework for future productive investigations. Research in other areas of mental retardation is also needed to form a complete picture of the problem at the various chronological and mental age levels.

Recommendations were as follows:

Office of Education

Support of research should be broadened to include investigation of many complex problems of mental retardation. For example:

- (1) There is a need for funds to support the development of new diagnostic instruments.
- (2) Research is needed in the area of collaborative and long-range studies in learning processes of the mentally retarded.
- (3) Traditional curriculums materials are rarely appropriate for the retarded. There is a need for a study of adult mental retardates at the various mental age levels to explore the relationship between curriculum development and specific psychological and educational factors relating to adult adjustment of the retarded. Research is needed to determine the design and relative effectiveness of various curricular materials and the approaches associated with them. The

production, try out, evaluation, reproduction, distribution, and use of materials to meet various needs and situations should be integral to the planning and support of research programs for the retarded.

(4) Further research is needed in the delineation of intellectual functions in the mentally retarded. Research indicates that intelligence is not a unitary process but composed of many factors; and there is a need for longitudinal studies to identify the specific intellectual functions in the development of the mentally retarded.

(5) A single, comprehensive, longitudinal study is needed to point up the interrelationships among the following factors: (a) the location of the mentally retarded at the preschool level; (b) changes in intellectual status during the school years; and (c) absorption of the mentally retarded adult into the community.

(6) There is a need to strengthen the research staff of the Office of Education in order to render field consultation services. It was also recommended that the review committee for research studies employ research specialists in mental retardation to determine the relevance of the problem to the field of mental retardation.

(7) It was recommended that Public Law 85-926 be expanded to include the training of specialists concerned with the auxiliary disciplines in the area of mental retardation.

Office of Vocational Rehabilitation

(1) Research in rehabilitation at an international level should be brought to the attention of American professional workers. Staff should be strengthened to achieve this end in order to coordinate, assimilate, and interpret these studies. The group agreed that utilization of knowledge of international developments in special education should be an important aspect of all programs for exceptional children and adults.

(2) There is also a need to implement the findings of existing studies concerned with the factors involved in the adequate vocational adjustment of the mentally retarded.

(3) It was also recommended that funds be provided for the additional training of vocational rehabilitation counselors in the problems of mental retardation and that additional inservice training institutes be sponsored for this purpose.

National Institute of Mental Health

(1) Research in mental retardation cuts across many biological and sociological disciplines. For example, it was recommended that sociological and psychiatric workers' studies be extended, particularly in the behavioral sciences, to include investigation into family, community, and environmental effects on mental retardates. Other suggested areas for research were: learning and personality factors; population studies of areas in which there is a high prevalence of mental retardation; and the impact of the mentally retarded on family and community life.

(2) Personnel-traineeships should be extended in areas auxiliary to education and rehabilitation of the mentally retarded in order to encourage trainees to undertake study of special problems and needs in mental retardation.

(3) It was recommended that training of psychologists in the field of mental retardation for direct work with educators be supported inasmuch as the psychologist's evaluation of the abilities of the mentally retarded is a central factor in planning individualized programs for these children.

General recommendation

There is a need to strengthen the Interagency Committee on Mental Retardation to coordinate the work of the units within the Department of Health, Education, and Welfare. For example, it was recommended that the services of the Office of Education and the Office of Vocational Rehabilitation be coordinated in order to facilitate the handling of certain needs of the mentally retarded in areas of education and rehabilitation, these needs being too extensive to be met by either agency alone. Demonstration of educational and vocational projects of a joint nature were suggested as were demonstrations of comprehensive community centers for vocational training.

ATTENDANCE SHEET, WORKSHOP IN SPECIAL EDUCATION AND REHABILITATION

I. I. Goldberg, chairman, Teachers College, Columbia University.

Kay Lynch, New York City Public Schools, BCRMD.

Anne Ritter, Kennedy Child Study Center.

Barbara Lake, Fordham University, School of Education.
 Brian Tomlinson, New York University School of Education.
 Anna Terubach, Institute for Retarded Children.
 Lillian Goldman, Bureau of Curriculum Research, Board of Education, New York City.
 Cornelia Belenkoff, Teachers College Mental Retardation Project.
 Sol Richman, New York State Division of Vocational Rehabilitation.
 Salvatore DiMichael, U.S. Office of Vocational Rehabilitation.
 Doris A. Perry, Teachers College, Columbia University.
 John A. Battle, Great Neck Public Schools.
 Thomas L. McCulloch, Letchworth Village (New York State Department of Mental Hygiene).
 Elkan E. Snyder, Graduate School of Education, Yeshiva University.
 Irving Ratchick, Director of Public Personnel Services, Levittown, N.Y.
 Isaac N. Wolfson, director, Letchworth Village.
 Arnold Fassler, Director of Special Education, Long Beach City Schools.
 Rick Heber, AAMD project.
 Dr. Charney, NARC.
 A. J. Lutkus, Bureau for Handicapped Children, State Education Department.
 William Fraenkel, NARC.
 Bernice A. Cornish, Teachers College, Columbia University.
 Kathleen Marko, Teachers College, Columbia University.
 Marietta Gruenert, Paterson State College, Paterson (Columbia University, Teachers College).
 Joseph Shostack, ex-director, Shield of David.
 Charles McAllister, Department of Mental Hygiene.
 Chris J. De Prosopo, cochairman, Associate Professor of Education, past president, American Association on Mental Deficiencies.

Mr. ELLIOTT. Our next group is that which considered problems pertaining to hearing disabilities and speech impairments.

The report for that group will be made by Dr. Moe Bergman.

STATEMENT OF MOE BERGMAN, COCHAIRMAN, WORKSHOP ON HEARING DISABLED AND SPEECH IMPAIRMENT, ACCOMPANIED BY CLARENCE O'CONNOR

Mr. BERGMAN. Dr. O'Connor has already appeared before your committee and has given a statement.

The following summarization is just that. There is a more lengthy report, which, with your indulgence, we will submit later.

Mr. ELLIOTT. Can you have it to us within 10 days?

Mr. BERGMAN. Yes, sir.

There were 30 specialists in the field of speech and hearing impairment meeting in these 2 days at Hunter College, along with other groups. I think the thing we were most impressed with was our most in the field, and that is interpreting the problem of speech and hearing challenging task which we have always known as professional workers difficulties to the public.

To all those who are not suffering from them themselves, that is. We have an old saying in our field in hearing that as far as deafness is concerned, it is awfully hard to sell it to the public because you cannot see it and nobody dies of it.

Similarly in the field of speech defects, the abnormality of stuttering, to my own way of thinking, and I have been in that for 22 years, is as serious a disorder as we have ever tackled on a national level.

I know it does not kill the body, as some of the diseases we have attacked, and successfully through Federal action, do, but believe me, gentlemen, it pulverizes the personality like nothing else we know.

Certainly it is clear to the individuals who suffer from speech and hearing loss and to their families, that of all our handicaps and all our disabilities, perhaps the inability to communicate with our fellow man is the most painfully isolating of all.

The most conservative statements indicate that at least 8 million persons in this country suffer from speech and hearing problems, so severe as to interfere significantly with their ability to live useful and productive lives.

In recent years, increasing information has been available on the diagnosis and treatment of persons with these problems. But, unfortunately, we are frustrated in the application of this information to the general population because of certain critical shortages.

First, to repeat what you have heard over and over these past 2 days, there is a distressing lack of specially trained persons necessary to provide the services, and enough training facilities to produce them.

Second, the required specialized physical facilities for diagnosis and treatment are woefully inadequate.

Third, the public is still seriously unaware of the enormous waste of human resources which accompany speech and hearing impairment, and, finally, there is a great need for research on the causes, prevention, alleviation, and/or elimination of these impairments.

The workshop committee urged Federal support to meet the shortages on a national level if possible.

I would like to state at this point that the group that prepared this report actually divided into three parts, one concerned with the problems of the deaf; another with the problems of the speech impaired; and the third with those of the hard of hearing.

The following report is that concerned with the problems of the deaf:

The workshop committee wishes to stress the desperate school conditions caused by the shortage of classroom teachers of the deaf. There are about 30,000 deaf children of school age in the country today. Approximately 500 specially trained teachers are needed for them each year.

At present there are less than 150 potential teachers under training, and a number of institutions which can provide the training have no trainees.

The lack of candidates for the training is due in great part to the extra training expense which is required beyond that needed for teaching a class of normal children.

A program of grants-in-aid to training institutions and to teachers in training is urgently needed.

A federally sponsored program is necessary also to provide fellowships for advanced training of college and university personnel to staff the teacher training programs.

Provision should be made for the development of persons for research, as well as administrative and supervisory personnel necessary to the education of deaf persons, which we would like to emphasize as much as we can, that much of the deafness and much of the speech problems which today seem to be beyond correction immediately, can, and ultimately, we believe, will yield, if enough intensive effort is given to this problem.

There are certainly straws in the wind that are extremely encouraging, developing of new surgical techniques for one type of deafness, but the type that puts the children in the school for the deaf is still relatively unyielding.

In addition, support is required for the orientation of such personnel as psychologists, psychiatrists, social workers, cottage or residential life personnel, otologists, and audiologists in the special problems of deaf persons.

Facilities: The committee recognizes the need for comprehensive evaluation centers for the early diagnosis of deaf children. It is recommended that Federal support be given to make possible the establishment of facilities, equipped and staffed for complete team action in the evaluation centers.

Today we know far more about it than yesterday, when we didn't know it was a problem. We find out that we have been misdiagnosing children for many years because of a shortage of knowledge.

There are many children who we formerly called deaf, for example, who we find today have disorders in the brain, brain injury, and who fail to develop speech in the manner that a deaf child does because of disorders in the brain which are not due to trouble in his ears, and which are still not clear in terms of how they happen, but even more frustrated is our inability to know what to do about these children, how to train them.

The need for research here is desperate. The diagnosis that is made at the age of 11 months, 7 months, and 4 months, even, can make the difference on the direction this child takes the rest of his life, and that direction can make a great deal of difference to all of us.

The committee recommends the establishment of area community centers for deaf adults where a full range of social, mental hygiene, family, and vocational guidance will be available.

Federal supporting grants are needed for the construction of the physical plants and to provide the multiple specialized services and personnel to manage the center.

There is need also for regional facilities of diagnosis and training for children with multiple handicaps who also have communication problems.

Public information: There is a need to bring to the attention of the public realistic information of the great potential of deaf persons for constructive work, and knowledge that the vast majority of them can find employment in the open market after appropriate training, there being no need for them to engage in such practices as begging or seeking subsistence through a dole.

The speech-and-hearing-impaired personnel: The workshop committee for the speech-and-hearing impaired stresses the critical need for personnel, to service some 8 million Americans of all ages who suffer from speech and hearing handicaps in addition to deafness.

It is estimated that at least 1,500 speech pathologists and audiologists, should be trained each year to staff the schools, hospitals, and community centers serving the speech-and-hearing impaired.

Since only about 400 specially prepared individuals are being graduated from colleges and universities at the present time, for service in this field, the workshop committee urges that a program of

grant-in-aid fellowships be provided to encourage greater numbers of candidates for training.

Further, the committee recommends Federal grants to the training institutions so that their programs can be increased to provide for the added student load.

Facilities: At the present time there are relatively few facilities for hard of hearing adult rehabilitation, and a similarly acute shortage of facilities for the preschool child with a severe speech or language, or hearing disorder.

As we have emphasized in other national conferences held before this workshop, there are relatively few facilities. This is hard to sell to the public, the effect of a partial loss of hearing, yet most of us face it in our loss.

The incidence of hearing loss between age 40 and 50 is increasing. I believe all of us know people close to us who are showing the effects of increasing isolation due to a loss of hearing in older age.

I might also digress for just a moment to emphasize the fact that the isolation that older people feel in the homes of their families and elsewhere is due not only to the fact that they no longer can go out and produce a day's work, but also because they can no longer communicate, and this is the most devastating of all isolations.

Physical facilities, modern electronic equipment, and highly trained personnel must be provided.

In particular, the development of centers for the differential diagnosis of auditory impairment in the preschool age child would represent a farsighted investment in the future, since early diagnosis in these cases is known to make a major difference in the way the child takes his place later as a member of the community.

There is, at present, Federal support for the rehabilitation of adults in certain categories. There appears to be a need to encourage some States to provide the required matching funds to realize the full potential of whatever legislative support is made available.

There appears to be need, however, for additional Federal action to provide for the rehabilitation of groups of adults not eligible for existing services, each as the following:

- (a) Older persons with small pensions or social security;
- (b) Persons of employable age, not considered potentially employable; and
- (c) The financially indigent persons for whom welfare and other public agencies now provide limited rehabilitation, often consisting only of the provision of a hearing aid, without training that goes with it.

It is suggested that provisions may be made for the rehabilitation of the foregoing groups under Federal legislation in much the same way that the National Rehabilitation Act now provides for adults who are potentially employable.

Since many geographic areas of this country are at present completely without services for auditory rehabilitation, it appears that such areas will require Federal financial encouragement to establish speech and hearing centers jointly with communities or regions.

The existence of such centers would insure more effective use of Federal funds now provided through such agencies as the Office of

Vocational Rehabilitation, but that would be in areas where facilities to utilize these funds effectively do not exist.

The committee recognizes the need for the establishment and expansion of facilities for year-round language and speech training for the child who has special speech problems.

There is a tragic break in the program in those communities fortunate enough to have speech correctionists during the summer months when much of the advantage gained during the year are lost entirely during the 3-month period.

This might be thought of in terms of camps or other institutions, supported by or, at least, encouraged by Federal action.

The committee urges the provision of services for the education of children with brain damage or atypical emotional development which interferes with the development of oral communication.

The committee on the speech impaired recommends the institution of periodic professional surveys to furnish reliable data on the incidence of the speech problem in persons of all ages, so that no one in need of speech rehabilitation will be overlooked.

I might say that the figure of 8 million that I mentioned was unpalatable to the workshop group. They felt it was far too low, because of percentages which they felt in their own experience were unrealistic.

But since we do not know exactly from a house to house count, and since the last census of hearing disorders, for example, was taken in 1935 and 1936, by the Public Health Service, we feel it is high time we had an authentic national survey of the incidence of both speech and hearing defects so that nobody who needs the service will be overlooked.

I would like to draw this to a rapid close, knowing the time pressure that you gentlemen are under, by talking just for a moment about research.

The tremendous human waste due to undiscovered, handicapping loss of hearing can be attacked on a national level through the encouragement and support of mass screening of hearing programs.

It is suggested that Federal aid sponsor basic research laboratories of the kind already established by the Federal Government in other areas be authorized for the study of audition and communication problems.

We are thinking of the type of programs that will be developed through industry and also through mobile testing units reaching the sections of the country not now serviced by large cities.

Such centers would be devoted primarily to basic services rather than to clinical service, so that the presently frustrating limitations in our knowledge of the mechanisms and causes of undeveloped communication in the young child can be overcome, through an intensive study of highly trained teams of investigators.

The Federal Government has made some inroads on that in Washington, but the need for that kind of a center certainly is great in many parts of the country.

The organization of such centers should be determined by an advisory committee established legislatively, working cooperatively with the appropriate Federal agency.

At the present time there is a wide variety of techniques employed in the schools in the screening and discovery of children with ear disease and auditory impairment in the schools.

There is urgent need for a Federal aid directed study of present and proposed methods to increase their effectiveness and efficiency of these methods.

Much confusion exists today on the exact incidence of hearing problems in our population. The last national study of hearing impairment in this country was accomplished in 1935-36. The need for an accurate study on a national level is obvious.

In summary, it is apparent that over 8 million Americans are suffering from correctable speech and hearing problems due to critical shortages of personnel and of special educational and rehabilitation facilities.

These shortages cannot be overcome unless attacked on a national level, through the kind of support that only the Congress can make possible through its legislative program.

Mr. ELLIOTT. Thank you very much, Mr. Bergman. I listened with a great deal of interest to that report, and I think it is very fine.

You and your coworkers are to be commended for the fine job.

(The following statement was submitted by Mr. Bergman:)

STATEMENT REGARDING THE UNMET NEEDS IN THE FIELD OF SPEECH AND HEARING
IMPAIRMENTS AND RECOMMENDATIONS FOR FEDERAL ACTION

The following is a summarization of the labors of 30 specialists in the field of speech and hearing impairment who met in a workshop at Hunter College, 695 Park Avenue, New York City, on October 27 and 28, 1959, from 9:30 a.m. to 4:30 p.m. A list of participants in the area of speech and hearing handicaps. is appended to this report.

INTRODUCTION

Of all the handicaps which can afflict a human being, perhaps the most painfully isolating disability for a person in modern society is the inability to communicate with one's fellow man. It may seem strange that the most challenging task for those of us concerned with speech and hearing impairment is to interpret to the public the devastating effects of such impairment on the development of the individual and on his status as a member of his community. There is an old adage about the difficulty of interpreting deafness to the public, "You cannot see it, and nobody dies of it." Similarly, while stuttering does not distort the body, it pulverizes the personality. How many Americans suffer from speech and hearing problems severe enough to interfere significantly with their ability to live useful and productive lives? The most conservative estimates available indicate that the number is somewhat over 8 million persons. In recent years increasing information has been available on the diagnosis and treatment of persons with these problems. Unfortunately, we are frustrated in the application of this information to the general population because of certain critical shortages. First, there is a distressing lack of specially trained persons necessary to provide the services, and of training facilities to produce them. Second, the required specialized physical facilities for diagnosis and treatment are woefully inadequate. Third, the public is still seriously unaware of the enormous waste of human resources which accompanies speech and hearing impairment. And finally, there is a great need for research on the causes, prevention, and alleviation or elimination of these impairments.

This workshop committee urges Federal support to meet these shortages on a national level.

Within the general category of speech and hearing problems there are three identifiable groups—the deaf, the speech impaired, and the hard of hearing. In the workshop in which this report was prepared separate groups gave their attention to each of these subareas.

THE DEAF

The following is the report of the professional group concerned with problems of deaf persons.

Personnel

The workshop committee wishes to stress the desperate school conditions caused by the shortage of classroom teachers of the deaf. There are about 30,000 deaf children of school age in the country today. Approximately 500 specially trained teachers are needed for them each year. At present there are less than 150 potential teachers under training and a number of institutions which can provide the training have no trainees. The lack of candidates for the training is due in great part to the extra training expense which is required beyond that needed for teaching a class of normal children. A program of grants-in-aid to training institutions and to teachers in training is urgently needed. A federally sponsored program is necessary also to provide fellowships for advanced college and university personnel to staff the teacher-training programs. Provisions should be made for the development of persons for research, as well as administrative and supervisory personnel necessary to the education of deaf persons. In addition, support is required for the orientation of such personnel as psychologists, psychiatrists, social workers, cottage or residential life personnel, otologists and audiologists in the special problems of deaf persons.

Facilities

The committee recognizes the need for comprehensive evaluation centers for the early diagnosis of deaf children. It is recommended that Federal support be given to make possible the establishment of facilities, equipped and staffed for complete team action in the evaluation centers, to all areas, including territorial possessions.

The committee recommends the establishment of area community centers for deaf adults where a full range of social, mental hygiene, family, and vocational guidance will be available. Federal supporting grants are needed for the construction of the physical plants and to provide the multiple specialized services and personnel to manage the center.

There is a need also for regional facilities of diagnosis and training for children with multiple handicaps who also have communication problems.

Public information

There is a need to bring to the attention of the public realistic information about deafness and deaf persons, about their great potential for complete education and training and for constructive work. Perhaps through the offices of the Department of Health, Education, and Welfare, the public should be informed that the vast majority of the deaf can find employment in the open market after appropriate training, there being no need for them to engage in such practices as begging or seeking subsistence through a dole. The workshop committee deplors the continued use of such obsolete terms as "deaf and dumb," "deaf mute," "mute," and other terminology which implies dramatically limited ability in deaf persons.

Research

There is a need for a federally supported study of the communication, emotional, and vocational problems of deaf persons, both children and adults, particularly oriented toward those who are born deaf or became deaf early in life. These and other urgently needed research studies should be the responsibility of the U.S. Office of Education, assisted by a legislatively sponsored Advisory Committee on the Deaf.

THE SPEECH AND HEARING IMPAIRED

Personnel

The workshop committees for the speech and hearing impaired stress the critical need for personnel, to service some 8 million Americans of all ages who suffer from speech and hearing handicaps. It is estimated that at least 1,500 speech pathologists and audiologists should be trained each year to staff the schools, hospitals, and community centers serving the speech and hearing impaired. Since only about 400 specially trained individuals are being graduated from colleges and universities at the present time, for service in this field, the

workshop committee urges that a program of grant-in-aid fellowships be provided to encourage greater numbers of candidates for training. Further, the committee recommends Federal grants to the training institutions, so that their programs can be increased to provide for the added student load.

Facilities

At the present time there are relatively few facilities available for hard-of-hearing adult rehabilitation, and a similarly acute shortage of facilities for the preschool child with a severe speech or language or hearing disorder. Physical facilities, modern electronic equipment, and highly trained personnel must be provided. In particular, the development of centers for the differential diagnosis of auditory impairment in the pre-school-age child would represent a far-sighted investment in the future, since early diagnosis in these cases is known to make a major difference in the way the child takes his place later as a member of the community.

There is, at present, Federal support for the rehabilitation of adults in certain categories. There appears to be a need to encourage some States to provide the required matching funds to realize the full potential of whatever legislative support is thus made available. There appears to be need, however, for additional Federal action to provide for the rehabilitation of groups of adults not eligible for existing services, such as the following:

- (a) Older persons with small pensions or social security;
- (b) Persons of employable age, not considered potentially employable; and
- (c) The financially indigent persons for whom welfare and other public agencies now provide limited rehabilitation, often consisting only of the provision of a hearing aid.

It is suggested that provisions may be made for the rehabilitation of the foregoing groups under Federal legislation in much the same way that the National Rehabilitation Act now provides for adults who are potentially employable.

Since many geographic areas of this country are at present completely without services for auditory rehabilitation, it appears that such areas will require Federal financial encouragement to establish speech and hearing centers jointly with communities or regions. The existence of such centers would insure more effective use of Federal funds now provided through such agencies as the Office of Vocational Rehabilitation.

The committee recognizes the need for the establishment and expansion of facilities for year-round language and speech training for the child who has special speech problems. The committee urges the provision of services for the education of children with brain damage or a typical emotional development which interferes with the development of oral communication.

The committee on the speech impaired recommends the institution of periodic professional surveys to furnish reliable data on the incidence of the speech problem in persons of all ages, so that no one in need of speech rehabilitation will be overlooked.

Public information

The committee urges that the public be given fair and objective information about persons with oral communication problems through the development of materials, films, and pamphlets on the nature of speech and hearing problems and on the potential for rehabilitation for persons so afflicted. A federally inspired program should disseminate information about speech and hearing disorders to well-baby clinics, pediatricians, general medical practitioners, and others. The urgency for recognizing and dealing with these problems as early in life as possible must be emphasized to insure the development of self-sufficient, self-supporting adults, and to provide vital clues as to the causes of the disorder. Encouragement should be given to the broadening of medical education to include recognition of significant early signs, since recent findings indicate that a considerable portion of the physician's time is spent on treatment of diseases of the ear, nose, and throat. We urge that Federal initiative and support be given to encourage the development of programs for orientation of parents of children with speech or hearing disabilities.

Research

The tremendous human waste due to undiscovered, handicapping loss of hearing can be attacked on a national level through the encouragement and support of mass screening-of-hearing programs.

It is suggested that Federal aid sponsor basic research laboratories of the kind already established by the Federal Government in other areas for the study of audition and communication problems. Such centers would be devoted primarily to basic service rather than to clinical service, so that the presently frustrating limitations in our knowledge of the mechanisms and causes of undeveloped communication in the young child can be overcome through an intensive study by highly trained teams of investigators.

The organization of such centers should be determined by an advisory committee established legislatively, working cooperatively with the appropriate Federal agency.

At the present time there is a wide variety of techniques employed in the screening and discovery of children with ear disease and auditory impairment in the schools. There is urgent need for a federally directed study of present and proposed methods to increase their effectiveness and efficiency.

Much confusion exists today on the exact incidence of hearing problems in our population. The last national study of hearing impairment in this country was accomplished in 1935-36. The need for an accurate study on a national level is obvious.

Summary

In summary, it is apparent that over 8 million Americans are suffering from correctable speech and hearing problems due to critical shortages of personnel and of special educational and rehabilitation facilities. These shortages cannot be overcome unless attacked on a national level, through the kind of support that only the Congress can make possible through its legislative program.

Respectfully submitted.

Dr. CLARENCE O'CONNOR, *Cochairman.*

Dr. MOE BERGMAN, *Cochairman.*

Dr. LEO E. CONNOR, *Recorder.*

Dr. Clarence D. O'Connor, superintendent, Lexington School for the Deaf.

Dr. Moe Bergman, director, Speech and Hearing Clinic.

Dr. Leo E. Connor, assistant superintendent, Lexington School for the Deaf.

Mr. David Altschuler, Division of Vocational Rehabilitation, New York State.

Dr. Godfrey Arnold, clinical director, National Hospital for Speech Disorders.

Mr. Daniel T. Cloud, superintendent, New York School for the Deaf.

Dr. Robert Dean, medical rehabilitation, medical director, Office of Vocational Rehabilitation, New York City.

Dr. Jon Eisenson, director, Speech and Hearing Clinic, Queens College.

Miss Katherine P. Geary, supervisor, teacher training, Junior High School 47.

Sister Rose Gertrude, superintendent, St. Mary's School for the Deaf, and Sister Regina.

Dr. Louise Gurren, director of speech improvement, board of education.

Dr. Dan Harrington, children's bureau.

Dr. Leola Horowitz, director, Speech and Hearing Clinic, Adelphi College.

Mrs. Shulamith Kastein, Speech and Hearing Clinic, Presbyterian Hospital.

Dr. Doris Leberfeld, Department of Hospital Speech Pathology, Flower-Fifth Avenue Hospital.

Mrs. Rosalind Levinson, placement, New York League for the Hard of Hearing.

Mrs. Dorothy Lewis, director, educational services, New York League for the Hard of Hearing.

Mr. Alby Lutkus, bureau for handicapped children, State education department.

Mr. Donald Markle, director, Speech and Hearing Clinic, Bellevue Hospital.

Miss Harriet McLaughlin, principal, Junior High School 47.

Mrs. Tanya Nash, director, Jewish Society for the Deaf.

Mrs. Eleanor Ronnei, executive secretary, New York League for the Hard of Hearing.

Dr. Paul Rotter, assistant to the superintendent, Lexington School for the Deaf.

Dr. Bruce Siegenthaler, Pennsylvania State University Speech and Hearing Clinic, representing American Speech & Hearing Association.

Dr. Robert West, professor of speech, Brooklyn College.

Dr. Emil Aabell, assistant director, Jewish Society for the Deaf.

Dr. Jane Zimmerman, professor of education, Teachers College, Columbia University.

Mr. ELLIOTT. Our next group is the neuromuscular and orthopedic impairment and chronic disabilities, and the chronically ill and disabled.

The neuromuscular and orthopedic impairment chronic disabilities group is headed by Dr. M. McCavitt and Dr. George Zukerman. The chronically ill and disabled group was headed by Dr. Frances Connor and Dr. Pollicoff. They, together, present their reports.

Dr. McCavitt and Dr. Connor, we are happy to have you and look forward to your reports.

STATEMENTS OF M. McCAVITT, COCHAIRMAN, WORKSHOP ON NEUROMUSCULAR AND ORTHOPEDIC IMPAIRMENTS AND CHRONIC DISABILITIES, AND DR. FRANCES CONNOR, COCHAIRMAN, WORKSHOP ON CHRONICALLY ILL AND DISABLED

Mr. McCavitt. Gentlemen, more than 50 individuals from New York State participated in our 2-day workshop study sponsored by the committee of special education and rehabilitation.

These men and women represented more than 40 public and private organizations and programs concerned with the evaluation, treatment, education, training, counseling, and placement of the multiple-handicapped men, women, and children.

They represented many disciplines and professions, including medical, social, educational, psychological, vocational, and recreational, at all levels of operation, supervision, planning, and management.

Initially, our plan called for the three separate workshops, one to represent the neurologically impaired, one to represent the orthopedically disabled, and a third to include all the chronically ill and disabled.

There was a strong feeling of these groups that we should meet jointly, at least initially, because of the many apparent needs of these ill and disabled, what they have in common, and particularly because of the thousands of individuals with multiple handicaps that may be included in one or more of the programs or groups.

Again, the need for joint effort was evident when the workshop sessions convened. The individual participants, too, unanimously felt that there was such commonality of problems and needs that they preferred to work through these areas and submit a joint report.

Represented in the thinking and planning were many separate and distinct diagnostic entities, including heart disease, cancer, multiple sclerosis, polio, muscular dystrophy, and cerebral palsy.

Also represented were individuals from such State and private organizations as the division of vocational rehabilitation, the State employment service, various public schools, private schools, and one representative from the Governor's committee on the employment of the handicapped.

This will give you some indication that we were concerned at all levels with this particular problem.

Dr. Zukerman, of course, from the board of education; Dr. Pollicoff, associate professor of physical medicine rehabilitation, Albany College, of Union University; Dr. Connor, associate professor at Teachers College, Columbia University, and myself, representing a private group, United Cerebral Palsy, New York City.

By agreement of the cochairmen the report of the workshop sessions would be divided into two parts; I will speak generally on rehabilitation needs and Dr. Connor will focus on the special education.

The workshop group wishes to take this opportunity to commend the Congress on the interest and the support of rehabilitation services to the disabled throughout the country for many, many years. They recognize, however, that the needs for extension of these services needed to be expanded and included, and we felt that perhaps very briefly we could define these and expand upon these, talk about these, under four headings.

One is services, the other personnel needs, the other research, and, finally, additional information under public education.

Under services of rehabilitation programs, we felt that independent living rehabilitation services need to be including evaluation and comprising both the diagnostic and the referral services, and that this agency should administer such programs and this determination should be made on the State level.

It was also felt that we should provide support for sheltered workshops, for individuals requiring long-term programs.

Under this heading, it was believed that consideration should be given to the provisions for the establishment of a central agency similar to the national industries of the blind that now exist for the procurement of such contracts for Federal agencies and the distribution of the contracts for sheltered workshops with homebound programs, and that a provision be made for the Federal agencies to fulfill their requirements for certain products through procurement from sheltered workshops and homebound programs.

Another need under the area of services was to provide support of demonstrations for the homebound, to include homemaking and housekeeping, recreation, education, and rehabilitation services for all ages, to provide support and demonstration projects for long-term residential care for the disabled.

Provision should also be made, it was felt, by the creation and support of a Federal interagency body to include both public and private agencies to collect and disseminate information and to coordinate and integrate services.

It was strongly felt that in order to provide and to take advantage and utilize all the services that are now in effect, or will be provided, that there will be some additional provisions made for transportation, or, at least, this problem would be studied, for individuals with multiple handicaps.

In the area of personnel, I had one or two recommendations to make, and this will be supplemented by Dr. Connors.

The first is the provision of training of personnel to increase the numbers requiring the training for additional neurologists, psychiatrists, nurses, clinical therapists, clinical psychologists, recreational therapists, and group workers, sheltered workshop personnel, rehabilitation counselors, and administrative personnel.

And also to provide for the support of personnel budget of facilities where no other sources of funds are available.

Under the heading of research, it was felt that there should be a continuation and extension of the present grants-in-aid program for basic clinical and Federal research in the areas of education, vocational and medical rehabilitation, that there should be support for projects to delineate the factors required for the comprehensive long-

term care of the disabled of all ages from preschool age through the aged.

Finally, under research, the support of projects to establish the actual incidence of the disabled and to maintain current State and/or regional registries of the disabled.

Our final recommendation under the heading of public information was in order to improve the efficiency, and we were very concerned about that throughout our entire workshop of 2 days, that the efficiency on the available services to the disabled, a need exists for the correlation and the education of information among all agencies, public and private, providing these services.

I would like to just say at this time that we appreciate coming, and Dr. Connor will supplement the area particularly pertaining to education.

Mr. ELLIOTT. Thank you very much.

Dr. Connor, you may proceed.

Dr. CONNOR. Reports of the U.S. Office of Education estimate that about 4 percent of the boys and girls in school would fit under this category that we are discussing this afternoon.

In the group are included youngsters with cerebral palsy, epilepsy, and some of them with brain injury that we put in quotes because although you don't have a manifestation of a physical abnormality there are some serious learning problems that they have.

Also are those children with special health problems.

As Dr. McCavitt said, those with cardiac conditions, rheumatic fever, and other conditions, as well as an increasing number of children who are diagnosed as having progressive conditions, such as cancer, leukemia, muscular dystrophy, multiple sclerosis, and other conditions.

These children were previously usually excluded from school because of the type of condition that they had, because they were becoming progressively less able to participate in school, they were more burdensome for teachers to manage, and very frequently were excluded from school.

Now, we find that more of them are attending schools in various ways.

As you know, some of these children, especially those with mild handicaps, go to school in the regular classroom, with regular teachers, with or without help from a person who is qualified to work with the youngsters specifically.

Other children attend special classes in special schools where they can get occupational therapy, physical therapy, speech; they have the services of a trained social worker and psychologist with their school program.

Others go to school while they are in the hospital, while under intensive medical care. Teachers are employed, we hope, by the boards of education, to go into the hospital and work with the children.

Other children go to school in their own homes. There are a lot of reasons for that. Some of the reasons are because the homes themselves are, because it is too difficult to get out of them in the morning, if they have to walk up and downstairs which they cannot mount, or because of transportation, which is a very expensive proposition.

Or because of the architecture of the school, the doors are too narrow to go into the building or they can't move around easily, or because the schools just don't have any special facilities or special classes which are desperately needed for them.

Or it might be because the children themselves have to remain in bed because they just don't have the physical stamina to do all those things we take for granted, like getting dressed, getting ready, getting to the bus, getting to the school, staying in a fairly upright position from 9 o'clock in the morning until 3.

But, nevertheless, we are providing in many communities programs of home instruction for these youngsters. We are very much concerned, however, about the lack of trained personnel and that often home instruction teachers are those people who have been encouraged or cajoled in some way to assume responsibility for going in and spending an hour or so with the child, or after he has been in school for a full day, or by getting volunteers to go in to schools and hospitals.

We believe they need some very good teachers.

With the parents concerned with service and community awareness of the problem, more and more severely handicapped children are coming into the school programs. Because of the complexity of their problems, which may be caused by the presence of one or more of the following—for instance, their fingers are involved so that they can't use pencils as other children do, they might have poor arm motion, they might have just lowered vitality, poor ambulation, just **highly** distractible youngsters who can't participate, or they might have speech difficulty so the teachers don't understand or can't afford to take the time to listen to the children—these people need very special teaching methods and materials and they need very special teachers, we believe.

Most important, and too overlooked, because of a high degree of specialization—this is moving to the other side of the picture—we are so highly specialized that we sometimes overlook the hearing difficulties of children, their vision problems, their mental retardation—all these areas that have been discussed by earlier group reports.

These are often overlooked because we have separated these particular children from the general population on the basis of a single or specific physical problem which we have mentioned.

Consequently, one of the major needs discussed by the workshop group was that of multiple handicaps.

Children don't come with just one handicap always, so we must look at it from a total picture.

The group strongly opposed the continuation of the fragmentation of programs for small groups of handicapped children. Such considerations in the workshop resulted in the following conclusions:

(1) We need highly qualified special education leadership at the local, the State levels, and in the colleges, to increase the number of effective teachers to work with children with varying degrees of handicaps and varying kinds of handicaps, not just specialists in one particular area.

This we felt could be done through the traineeship program for the preparation of educational supervisors, administrators and college

teachers, as well as the supporting grants to the training institutions as has been legislated for the mentally retarded.

(2) To assure the utilization of these well qualified educational leaders, the workshop participants asked that you be apprised of the need for support of the personnel budgets of comprehensive special education and rehabilitation facilities where no other sources of funds are available.

This was inspired by the fact that we can have highly qualified persons to work in colleges. They have come from a school system where there have been expert teachers, highly recognized, earning, let me say, \$6,000.

Now they have been trained to work in a college, and you know what the college salaries are.

Some of the States are begging us for personnel for their teacher education programs, but they are offering salaries like \$4,200, \$4,500, and our people are saying "Should we go there?"

We felt that if we were going to train these people and they are going to come in with good academic backgrounds and good experience backgrounds there should be places for them to go with enough satisfaction in the job so that they can use the talents that they have.

(3) We need to know who these children are, really, where they are, and what their problems are.

Thus, we, too, recommend the establishment and maintenance of current either State or local or regional registries on a nationwide basis, so that we have comparable data throughout the country and we know who these children are and what their needs are, not how many have cerebral palsy, but what they need.

If we had something consistently reported, we believe we would have a basis on which to operate.

(4) We want to know more about the learning problems of children and the impact of chronic illness and progressive and deadly conditions, such as cancer and muscular dystrophy on the child, on his family, and on the teacher.

What does that mean to the teacher with a certain set of values to work with children who aren't going anywhere. Maybe they are going to die in the next couple of years.

We believe we have to know more about the impact of these conditions on the child, his family and the teacher, too, and we might say that we are gratified by the Federal grants for basic and field research in education, particularly through the Office of Education, because through these we have been able to look critically at some of the important aspects of education.

We urge your continued support of such research grants.

(5) And lastly, we were stimulated by the effects of this interdisciplinary and interagency workshop which we have just completed, despite the fact we are tired.

The group has asked for Federal support of an interdisciplinary character or of an interdisciplinary conference on national and regional levels to be held at regular and frequent intervals.

Such conferences might follow the pattern of the White House Conference, but maybe we could ask for them a little more often than the White House Conference.

We believe that through the comprehensive program of education and care of the handicapped, individuals from the preschool ages, the little tiny tots, to the aged, will restore their personal dignity, will enrich our society and help us utilize the potential of our citizens.

Thank you very much.

Mr. ELLIOTT. Thank you both. Your reports were very fine and we appreciate them.

(The following statement was submitted by Dr. McCavitt:)

WORKSHOP OF NEUROMUSCULAR AND ORTHOPEDIC IMPAIRMENTS, CHRONICALLY ILL AND DISABLED

Dr. Martin McCavitt, Dr. George Zuckerman, Dr. Frances P. Connor, Leonard Pollicoff, M.D.

The committee on chronic illness and disabilities in conjoint with the committee on orthopedic disabilities and physically handicapped workshop section presents the following reports based on the unanimous opinions of those participating.

The following needs are felt to exist :

I. IN THE AREA OF RESEARCH

(a) Continuation and extension of the present grants in aid program for basic clinical and field research in the areas of education, vocational, and medical rehabilitation.

(b) Support of projects to delineate the factors required for the comprehensive long-term care of the disabled at all age levels.

(c) Support of projects to establish the actual incidence of disabilities and to maintain current State and/or regional registries of the disabled.

II. PERSONNEL

(a) Provision of training of personnel to increase the numbers of required personnel in short supply including neurologists, psychiatrists, nurses, physical therapists, occupational therapists, clinical psychologists, social workers, recreation therapists, recreation group workers, sheltered workshop personnel, rehabilitation counselors, and administrative personnel.

(b) To increase the supply of teachers and to improve the quantity of instruction for children with chronic medical problems, neurologically orthopedically and orthopedically disabled through training grants for leadership personnel including education supervisors and administrators and college teachers with supporting grants to the training institution, as is already legislated for the area of the mentally retarded.

(c) Provide funds for the support of the personnel budget of comprehensive special education and rehabilitation facilities where no other sources of funds are available.

III. SERVICES

(a) Need for extension of rehabilitations services to independent living rehabilitation services to include evaluation comprising both diagnosis and referral.

(b) The agency to administer such programs shall be determined by the individual State.

(c) Transportation: In order to utilize services existing and projecting, provision for transportation of disabled individuals is essential.

(d) Provide support for sheltered workshops for individuals requiring long-term programs.

(e) Provide support of demonstration projects for the homebound to include homemaking and housekeeping, recreation, education and rehabilitation services at all age levels.

(f) Provide support of demonstration projects for long-term residential care of the severely disabled.

Provision should be made for the creation and support of a Federal inter-agency body, to include both public and private agencies, to collect and disseminate information and to coordinate and integrate services.

IV. IMPROVED EFFICIENCY

In order to improve the efficiency of available services to the disabled, a need exists for the correlation and exchange of information among all agencies, public and private, providing such service.

(1) That disciplinary conferences supported by Federal funds be held, on a national and regional level, at regular and frequent intervals.

It is therefore recommended that—

(a) There is a need for providing better sources of information to the general public on the availability of services and to disseminate such information through the various media of communication.

(b) There is a need for greater public knowledge of the educational and employable potential of the disabled.

This workshop recommends, in addition to the above, that the major problem existing in the education and rehabilitation of the disabled is the provision of comprehensive services to the multiple handicapped.

ATTENDANCE LIST

L. D. Policoff, Albany Medical College.
 Jay Schleichkorn, United Cerebral Palsy Association, New York State.
 Edward Kilbane, United Cerebral Palsy, New York State.
 K. Allan, Cancer Care.
 Leonora B. Rubinow, National Association of Social Workers.
 Evelyn McNamara, the National Foundation.
 Grace C. McCandless, Bureau for Education of the Physically Handicapped.
 Edna M. Lawrence, Vocational Advisory Service.
 Anne Altman, New York State Employment Service.
 Irving M. Friedman, Governor's Committee on Employ the Physically Handicapped.
 Ralph Abramson, Federation of the Handicapped.
 Anna J. Kalmanowitz, New York Heart Association.
 Howard Riley, New York Teachers College, Columbia University.
 Frances J. Barnes, Teachers College, Columbia University.
 Edward LaCrosse, Teachers College, Columbia University.
 Gloria F. Wolinsky, Hunter College.
 Anna C. Smerka, Lackawanna Board of Education.
 Joseph J. Endrus, National and State Society for Crippled Children and Adults.
 H. Michol-Smith, New York Medical College, Flower-Fifth Avenue Hospital.
 Robert C. Darling, Columbia University, College of Physicians and Surgeons.
 Harry Katz, D.V.R. New York City.
 Roland H. Spaulding, School of Education, New York University.
 Rose Marie Hernandez, National TB Association.
 Mona G. Bronson, United Cerebral Palsy of New York State.
 Margaret A. Losty, Bureau for Handicapped Children, New York Department of Health.
 Harry Sands, United Epilepsy Association.
 Ralph Cancro, Burke Foundation.
 George Zuckerman, Board of Education, New York City.
 Beatrice V. Hill, National Recreation Association.
 Juliana Simpson, National Recreation Association.
 Abraham Lieberman, State workmen's compensation board.
 D. S. Schilling, Board of Cooperative Educational Services.
 Martin McCavitt, United Cerebral Palsy of New York City.
 Harry Lyons, United Cerebral Palsy Association (national).
 Frances P. Connor, New York Teachers College, Columbia University.
 Helen B. Holodnak, National Multiple Sclerosis Society.
 J. Morrison Brady, M.D., Muscular Dystrophy Association of America.
 Leonard Diller, Institute of Physical Medicine and Rehabilitation.
 I. Jay Brightman, M.D., State and Interdepartmental Health Resources Board.
 John Cummings, New York State Division of Vocational Rehabilitation.
 Lawrence Taft, M.D., Albert Einstein College of Medicine.
 Lucy Blair, American Physical Therapy Association.
 Mrs. Galloway Cole, United Epilepsy Association.
 Jerry G. Cochran, Teachers College, Columbia-Recorder.
 Richard Lubell, board of education, special assistant director, child welfare.
 Emil A. Lombardi, C. P. School, Roosevelt, N.Y.

Alby T. Luthin, B.H. Children, State educational department.
 W. K. Shaughnessy, Community Council of Greater New York.
 Marcus Arnold, board of education.
 James Burrows, ICD.
 Sol Feingold, UCP of Queens.

Mr. ELLIOTT. Our next group is the group on limited vision, headed by Mrs. Helen Fields, Miss Helen Gibbons.

STATEMENTS OF MRS. HELEN FIELDS AND MISS HELEN GIBBONS, COCHAIRMAN, WORKSHOP ON LIMITED VISION

Mrs. FIELDS. Miss Gibbons will read.

Miss GIBBONS. First, may I say that we as a group are appreciative of the opportunity to present the report on the thinking of the group of people interested in the limited vision.

This material is the consensus report of a group made up of those interested in rehabilitation, in ophthalmology and in education.

It is the opinion of this group that very little emphasis has been placed on providing adequate services to partially seeing children, youth, and adults.

Historically, the legally blind have been expected and thought of as a distinct group, but the partially seeing have been sadly neglected.

It must be recognized that the partially seeing are a separate group with problems different from those of the blind, requiring special techniques and services.

The partially seeing group of children, youth, and adults, are immeasurably larger than the easily definable legally blind. There is a need for recognition and redefinition of the term "limited vision," which is more commonly referred to as visually handicapped.

At the present time, the term "limited vision" includes—

(1) The partially seeing who have corrected vision of 20/70 or less;

(2) The legally blind who use print;

(3) The legally blind who use braille; and

(4) Any person who, in the opinion of a qualified diagnostic team requires special education and rehabilitation services.

The term "visually limited" should be redefined to include all individuals who, by virtue of ocular pathology are educationally or vocationally limited.

The partially seeing are the greatest number of this group.

Therefore, it is recommended that a Federal grant be allotted for study of the total number of partially seeing in all school enrollment as a continuing study of spotchecks made by the National Society for Prevention of Blindness, estimating that 1 in 500 partially seeing are in our school enrollments.

The purpose of such a study would be to provide a basis to justify the need for adequate educational and rehabilitation services for this group.

There is a general shortage of qualified professional personnel, that is, teachers, psychologists, psychiatrists, social workers, educational guidance and rehabilitation counselors, doctors and nurses, needed to provide services to partially seeing persons.

This group is vastly larger than now being served under the definition of legally blind.

Since it is estimated that there are 4,000 public school partially seeing children in New York State, there is a great need to recruit and prepare qualified teachers and supervisors.

It is estimated that 270 teachers are needed to bring services to these children.

If colleges and universities are to establish and staff necessary courses of preparation, there is need to supplement funds available for such training courses, from Federal moneys.

Therefore, it is recommended that the National Defense Education Act include traineeships for personnel preparing to teach at the college level in the field of partially seeing, funds to assist the recruiting of such personnel, that Federal funds in the form of grants in aid or scholarships, fellowships, or traineeships to colleges, universities, and specialized schools be made available and increased in order to train qualified professional personnel, including among them beyond the teachers, the doctors, the nurses, the psychologists and psychiatrists, social workers, educational guidance and rehabilitation counselors, so that they can have a better understanding of the educational, vocational, and rehabilitation implications of ocular defects, and so that adequate services can be provided for the partially seeing.

That financial assistance be granted to colleges, universities, and specialized schools, to include essential courses in their curriculums dealing with the problems of the partially seeing group.

That Federal funds be allotted for the provision of inservice training seminars, in extensive short-term training and workshops for practitioners in the various disciplines as well as for administrators.

There is a need for extension of special educational supplies and equipment to service any partially seeing individual in need of the same materials which are now provided by the Federal Government only to the legally blind.

Therefore, it is recommended that any visually handicapped individual requiring special education, training, and rehabilitation, should have available to him all existing materials purchasable on quota account from the American Printing House for the Blind.

There is need for increased development, publication, and distribution of more books and equality for all visually limited persons who use print in order to provide equality of education for them.

Therefore, we recommend that the American Printing House be encouraged to expand its facilities and be permitted to purchase from the manufacturers of books, machines, or equipment from any established and reputable source, and that the distribution quota be expanded to take care of all the needs of each State without regard to the present limitation of \$30 per capita.

There is a serious lack of rehabilitation centers which can provide appropriate services for the partially seeing in terms of complete evaluation, vocational training, family counseling, and research.

At present, only a few of the existing private rehabilitation centers for the blind accept the partially seeing for limited service.

Some of the private rehabilitation centers working with handicapped groups have expressed concern about working with partially seeing because of their limited knowledge about this group.

Therefore, it is recommended that Federal funds be allotted for the support of rehabilitation centers, which, as a part of their program,

can provide adequate services to the partially seeing in terms of casework, testing, evaluation, and vocational training for independent living, and placement, as well as expansion of present rehabilitation centers.

There is a general dearth of long-range workshops for the severely handicapped throughout New York State. The existing ones are privately operated and, to a degree, depend upon their own production for their continuation, so that a large proportion of severely handicapped persons cannot be accepted because they do not meet production standards.

In addition, the existing workshops are very limited in the types of services and vocational activities offered. There is also a need for research on the problems of the partially seeing, who cannot compete in private industry.

Therefore, it is recommended that Federal funds be allotted for the expansion of existing private workshops and for the support of New York shops to promote remunerative employment to the partially seeing who cannot readily be absorbed in the competitive labor market.

These workshops should provide evaluation of work potential, developments of working capacity, remunerative employment, and placement.

Now, we come to our last item, research needs in educational and rehabilitation material for the partially seeing individuals.

Since the partially seeing represent a large segment of our population, there is an evident need for a Federal roster to acquire constant knowledge of the diseases resulting in partial vision. For example, in the conquest of retrolental fibroplasia, statistical knowledge alone played a major role.

And, secondly, to determine educational needs; and thirdly, to help determine the extent of rehabilitation services needed.

Good school placement, rehabilitation programs, depend to a great extent on effective measurement and evaluation, aptitude, intelligence, personality.

Present instruments of measurement are largely visual ones. Therefore, we recommend that there is a need for intensified research in the direction of more valid psychological testing, the results of which will not be matched by the visual handicap.

Many ocular defects are easily remedial during early childhood. The same defects may be resistant to all forms of treatment during the rest of the individual's life.

Therefore, we recommend that there is a great need for case finding of infants and preschool children with visual defects and recommend that Federal funds be allocated for research into the development of more adequate and effective methods of vision screening.

At present, all large type materials published by the American Printing House and private sources are printed in 18- and 24-point type.

Neither of these type sizes are equally effective for all partially seeing individuals.

There is a great variation in a person's ability to use these type sizes effectively. Therefore, it is recommended that there is a need for re-

search to determine what type sizes are most useful for partially seeing individuals.

And, lastly, at present the clinical programs for the development and use of low vision aids have effectively helped partially seeing persons.

Therefore, we recommend that Federal funds should be allotted for an expansion and coordination of the scattered efforts made now to provide optical aids.

Mr. ELLIOTT. Thank you very much, Mrs. Gibbons.

Mrs. FIELDS. I would like to say that this represents interagreement of all members of the group.

Mr. ELLIOTT. Thank you so much, Mrs. Fields.

Let me say to the eight groups who have worked long and hard in the workshops sponsored by the study group of our subcommittee that I think that the results of your work is the most effective evidence that has been brought before a congressional committee that I have had the privilege to serve on.

The committee is deeply indebted to you for it.

Also, we want to express to Dr. Elena Gall, professor of special education, and director of the field studies for our special education and rehabilitation study, the expressed thanks of the committee because she has been in charge, along with Dr. Fenton, of the organization of this workshop held at Hunter College, from which this very up to date and very effective testimony has come to us.

(The following statement was presented by Mrs. Fields:)

REPORT OF WORKSHOP SPECIAL EDUCATION AND REHABILITATION—LIMITED VISION

Cochairmen: Helen W. Fields, Helen G. Gibbons

INTRODUCTION

It is the consensus of this group that very little emphasis has been placed on providing adequate services to partially seeing children, youth, and adults. Historically, the legally blind have been accepted and thought of as a distinct group, but the partially seeing have been sadly neglected. It must be recognized that the partially seeing are a separate group, with problems differing from those of the blind and requiring special techniques and services. The group of partially seeing children, youth, and adults is immeasurably larger than the easily definable legally blind group.

NEED

1. There is a need for recognition and redefinition of the term "limited vision," more commonly referred to as "visually handicapped." At present the term "limited vision" includes:

(a) The partially seeing who have corrected vision of 20/70 or less.

(b) The legally blind who use print.

(c) The legally blind who use Braille.

(d) Any person who, in the opinion of a qualified team, requires special education and rehabilitation services.

The term "visually limited" should be redefined to include all individuals who by virtue of ocular pathology or refractive error are educationally or vocationally limited. The partially seeing make up the greatest number of this group.

It is therefore recommended

That a Federal grant be allotted for study of the number of partially seeing in the total school enrollment as a continuing study of "spot checks" made by the National Society for the Prevention of Blindness and disclosing an estimated 1 in 500 of the school population to be partially seeing. The purpose of such

a study would be to provide a basis to justify the need for more adequate educational and rehabilitation services for this group.

2. There is a general shortage of qualified professional personnel—teachers, psychologists, psychiatrists, social workers, educational guidance and rehabilitation counselors, doctors and nurses—to provide adequate services to partially seeing people. This group is very much larger than those now served under the definition of legally blind.

It is therefore recommended

That the National Defense Education Act legislation include—

(a) traineeships for personnel preparing to teach at the college level in the field of the partially seeing;

(b) funds to assist in recruiting such personnel.

3. There is a great need for case finding of infants and preschool children with visual defects. Many ocular defects are easily remediable during early childhood; these same defects may be resistant to all forms of treatment during the rest of an individual's life.

It is therefore recommended

That Federal funds be allotted for research in the development of more adequate and effective methods of screening in these areas.

4. At present all large-type materials published by the American Printing House for the Blind and by private sources are printed in 18- or 24-point type. Neither of these type sizes is equally effective for all partially seeing individuals. There is great individual variation in the ability of persons to use these type sizes effectively.

It is therefore recommended

That Federal funds be allotted for research to determine what type sizes are most useful for partially seeing individuals.

5. At present clinical programs for the development and use of low-vision aids have effectively helped many partially seeing persons.

It is therefore recommended

That Federal funds be allocated to the expansion and coordination of the scattered efforts made to provide optical aids.

6. There is a serious lack of rehabilitation centers which can provide appropriate services for the partially seeing in terms of complete evaluation, vocational training, family counseling, and research. At present only a few of the existing private rehabilitation centers for the blind accept the partially seeing for limited service. Some of the private rehabilitation centers working with handicapped groups have expressed concern about working with the partially seeing because of their limited knowledge about this group.

It is therefore recommended

That Federal funds be allotted for the support of rehabilitation centers which, as a part of their program, can provide adequate service to the partially seeing in terms of casework, testing, evaluation, and vocational training for independent living and placement, as well as for expansion of the present rehabilitation centers.

7. There is a general dearth of long-range workshops for the severely handicapped throughout New York State. The existing ones are privately operated and, to a degree, depend upon proceeds from their own production for continuation so that a large proportion of severely handicapped persons cannot be accepted because they do not meet production standards. In addition, the existing workshops are very limited as to types of services and vocational activities offered. There is also a need for research on the problems of the partially seeing who cannot compete in private industry.

It is therefore recommended

That Federal funds be allotted for the expansion of existing private workshops and for the support of new workshops to promote remunerative employment to the partially seeing who cannot readily be absorbed in the competitive labor market. These workshops should provide evaluation of work potential, development of work capacity, remunerative employment, and placement.

Research needs in educational and rehabilitation material for partially seeing individuals.—Since the partially seeing represent a large segment of our population, there is evident need for a Federal roster—

(a) to acquire constant knowledge of the diseases resulting in partial vision (in the conquest of retrolental fibroplasia statistical knowledge alone played a major role);

(b) to help determine educational needs;

(c) to help determine the extent of rehabilitation services needed.

8. Good school rehabilitation programs depend to a great extent on effective measurement and evaluation of aptitude, intelligence, and personality. Present instruments of measurement are in a type size not easily readable by many of this group.

It is therefore recommended

That Federal funds be allotted for intensified research in the direction of more valid psychological testing, the results of which will not be masked by the visual handicap.

9. Since it is estimated that there are 4,000 partially seeing children in the public schools of New York State, there is a great need to recruit and prepare qualified teachers and supervisors. (It is estimated that 270 teachers are needed to provide services to these pupils.) If colleges and universities are to establish and staff necessary courses of preparation, there is need to supplement funds available for such training courses from Federal moneys.

It is therefore recommended

(1) That Federal funds in the form of grants-in-aid as scholarships, fellowships, or traineeships to colleges, universities, and specialized schools be made available and increases in order to train qualified professional personnel—teachers, doctors, nurses, psychologists, psychiatrists, social workers, educational, guidance, and rehabilitation counselors—so that they can have a better understanding of the educational, vocational, and rehabilitation implication of ocular defects and so that adequate service can be provided for the partially seeing.

(2) That Federal funds be allocated for financial assistance to colleges, universities, and specialized schools to include in their curriculums essential courses dealing with the problems of the partially seeing.

(3) That Federal funds be allotted for the provision of inservice training seminars, intensive short-term training, and workshops for practitioners in the various disciplines as well as for administrators.

10. There is a need for extension of special educational supplies and equipment to service any partially seeing individual in need of some of the materials now provided by the Federal Government only for the legally blind.

It is therefore recommended

That any visually handicapped individual requiring special education, training, and rehabilitation should have available to him all existing materials purchasable on quota account from the American Printing House for the Blind.

11. There is need for increased development, publication, and distribution of more books and equipment for all visually limited persons who use print, in order to provide equality of education for them.

It is therefore recommended

That the American Printing House for the Blind be encouraged to expand its facilities and be permitted to purchase from any established and reputable source books, machines, or equipment; and that the distribution quota of the American Printing House for the Blind be expanded to take care of all the needs of each State without regard to the present limitation of \$30 per capita.

Attendance List, October 27, 28, 1959, Hunter College

Edward Burke, Board of Education, New York City, Guidance-Visually Handicapped.

Leona Wasserman, Vocational Education and Extension Board, County of Nassau.

Sara Wasserman, Division of Vocation, Rehabilitation, New York City.

Helen Gibbons, National Society for Prevention of Blindness.

Walter S. Schachat, New York City Department of Health.

Charles R. Wallendorf, Vocational Education and Extension Board, County of Nassau.

Helen W. Fields, board of education, bureau for visually handicapped.

Mr. ELLIOTT. At this time also, I would like to recognize the presence of Dr. Romaine Mackie. Dr. Mackie is the head of the Division of Exceptional Children of the U.S. Office of Education.

Dr. Mackie, to my knowledge, has spent these 2 days here listening to the evidence that the committee has been privileged to hear.

We have been happy to have you, Dr. Mackie, and we appreciate your presence.

STATEMENT OF ROMAINE MACKIE, DIVISION OF EXCEPTIONAL CHILDREN, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, WASHINGTON, D.C.

Dr. MACKIE. I do feel moved, Your Honor, Mr. Elliott, to express a word of appreciation. This is the first in the series of hearings, and I wanted especially to come here because of our interests in your work; also, because although New York is not my native State, in many ways it more or less adopted me and contributed some things to me for which I shall forever be grateful.

It began when Dr. Frampton provided me with a fellowship study at Columbia University, and it has provided me since then with inspiration from some of the students I had the honor of teaching in this city, two of whom were Dr. Gall and Dr. Connor, whom you heard.

I could not refrain from making these comments and to also assure you of the confidence you have placed in the Office of Education in the new fellowship program, concerning which many people are expressing appreciation to Congress. I refer to Public Law 85-926.

I also want to pledge the efforts of the Office of Education to try to carry forward in the direction the people are indicating.

Thank you.

Mr. ELLIOTT. Thank you, Dr. Mackie.

Did Lee J. Dowling come in?

Did Dr. J. Morrison Bradley?

Sylvia Golden?

Horace Mann?

Mr. Herman Melvin? I believe I was told he would not be here.

Our next two witnesses will testify together. They are Dr. Gunnar Dybward and Dr. Elizabeth Boggs, representing the National Association for Retarded Children. We are very glad to have you with us.

STATEMENTS OF GUNNAR DYBWARD AND ELIZABETH BOGGS

Mr. ELLIOTT. May I say that I distinctly remember the very fine work that Dr. Boggs and Dr. Dybward and their associates did, helping to create the climate, knowledge, and opinion that led eventually to the passage of Public Law 85-926, the bill for the teachers of the mentally retarded.

We passed that law on the last night of the 2d session of the 85th Congress, quite too late to obtain an appropriation for the bill for the first part of this year. But I am happy to say that in the recent session of Congress we did provide an appropriation of the full

amount authorized under the bill, with which to begin work under that law.

Having said that, Drs. Boggs and Dybward, I feel as though I am taking your time, so I will let you proceed.

We have had a rule that we try to limit the testimony to the 30-odd witnesses we heard today to about 10 minutes. I think since two of you appear together the rule will be 15 minutes.

Dr. Boggs. We will try to do this in 10, Mr. Elliott.

We appreciate your patience in this prolonged hearing. I assure you I have no intention of reading what is in that red book, although I hope it may form a resource for your committee at a later date.

Mr. ELLIOTT. Let me say that the full testimony of Dr. Boggs will be placed in and made a part of the record, following her whole statement.

Dr. Boggs. We also included in that report the evaluation report we included for the White House Conference, because we felt it was relevant, but we don't expect to include that as part of the official testimony.

I would like to start by saying that 10 years ago there was no national voluntary citizen organization which was focusing on a comprehensive and continued look at the needs of the group we call the mentally retarded.

The NARC has been organized since then, and has undertaken to apply itself in a broad way to a category of people which is as comprehensive. I think, as the one to which work groups 6 and 7 addressed themselves, and one where not only are there a great variety of individuals whose disability has been variously caused but also one in which, for any one individual, there are many aspects of disability.

In fact, the disability of mental retardation affects almost everything about the life of a retarded individual, from very early in his life until the very end.

We feel heartened by the response that the community, community agencies, and governmental at all levels has shown toward the needs as expressed and focused upon by coordinating citizen interest, which we feel we are the vehicle to express.

I think it is important to express that because of its heterogeneity and because of the various aspects of the life of the mentally retarded, we find ourselves naturally drawn to work closely with a great variety of other agencies.

To mention only two with which we have worked at the national level, and with which you are particularly concerned, the Council for Exceptional Children—the educational organization in the field of the handicapped—and the National Rehabilitation Association are among the people whom we regard as our organizational friends.

It has been said that if two men agree 100 per cent, one of them is unnecessary. I think it would be very unhealthy if everybody agreed on everything all the time.

But we feel that where there are disagreements in our field, these are the healthy kind which produce progress, and that to a remarkable extent various organizations, professional and lay, which overlap from various ways, have been able to arrive at very substantial agreement on many of the things with which you are concerned, and I think we

have shown our ability, our flexibility, in this respect, with regard to suggestions with respect to Federal legislation.

One of the important things in my view, and in our view, about the response in the past 10 years of the community, both through voluntary agencies and through the tax-supported agencies, has been the extent to which it has enabled both the retarded individual and his family to come back to function in a way so that they can assume their own responsibilities with respect to this problem.

Previously, the individual who did not get help was submerged and the family often was overwhelmed and submerged and became, itself, a social casualty.

All of these things have been improved by the direct services which have been made available, and these are services, of course, primarily not the direct responsibility of the Federal Government.

We have given a lot of thought to the role of the nonpublic agencies, the role of the various levels of government, and the role of the individual in this whole picture, which is very complicated.

We do appreciate the activities of the Federal Government, which are designed to stimulate the States to do the things which the States ought to do. We feel this is so important nationally because in our highly mobile society what isn't done in one State often arrives in another State's lap at a later date as a dependent person.

However, I would like to stress particularly the important role of the Federal Government in professional training and research in these areas. I know you have heard this said many times in the past 2 days. We can only say that we concur.

Both in the field of rehabilitation and in the field of special education we have relatively few Federal areas in the areas of respectively professional training and research.

I would like to mention two or three specifics, and I know you are interested in that, too, where you might consider things to be done. For example, the cooperative research law has been determined to prohibit or not to allow grants to a residential institution which is caring for a large number, training and rehabilitating a substantial number, of mentally retarded individuals.

This happens to be precluded in the wording of the law, and yet these institutions are often the places where not only do you have the subjects for the experiment, but you have a concentration of qualified personnel.

By the same token, the specific question of training people for research and education is not adequately covered. The cooperative research program does not provide for the training of personnel.

It provides for the conduct of research.

The expectation which we originally had of Public Law 85-926 was not realized when the term "for research" was amended out of that bill before it was passed.

I would like to underwrite and support the suggestion for the expansion of 85-926 to include other types of handicapped, other than the mentally retarded.

We have been for this right from the start, although we recognize that in an experimental bill it was well to confine this to one area.

We believe that it would be very valuable, as has been mentioned by several other witnesses here, that flat grants to universities to get a

new program of professional training established should be available to precede the granting of fellowships, tied in with the granting of fellowships.

Finally, let me say that sometimes I think Congressmen worry a little too much about overlapping and duplication in the Federal offices in the Department of Health, Education, and Welfare. I think that we need a little bit more overlapping and what you should insist on is that the overlapping be productive and cooperative and not competitive.

Just in the areas that you are interested in, special education and rehabilitation, we need very close dovetailing. Sometimes by insisting that they not overlap, you prohibit them from even getting together, getting close to one another.

Now, may I turn this over to Dr. Gunnar Dybward for a few remarks.

Mr. ELLIOTT. Thank you very much, Dr. Boggs.

Dr. Dybward.

Dr. DYBWARD. Mr. Chairman, it is a real privilege to appear before a committee that has given such splendid leadership in our field. I am very conscious of the time and I shall condense my remarks to a minimum.

Before I address myself to some of the specific problems in education and vocational rehabilitation, the focal points of your committee's activity, I would like to emphasize that much of what we will plan, are planning and have already accomplished in those fields, is to little avail if we do not have adequate diagnostic services in early childhood, long before the school or special education is coming to these children.

For that reason, I want to underline what has been said by some of the committees with regard to this.

We certainly have been most grateful for what has been accomplished through the grants Congress has made to the Children's Bureau, in terms of establishing the special mental retardation clinics, but we have too few of them, and those we have are serving too large a territory, have waiting lists of them 6 months to several years, and at the same time we do have definite scientific evidence that at least in some of the cases of mental retardation very serious damage results if there is no early diagnosis, and with all of them there is an unnecessary delay which really spells deterioration, if we don't have very early, for the parents, an estimate of the child's capacity at that particular point, and some help in management and training.

We have now on record a study by Dr. Kirsch, of Illinois, which was published in the form of a book very recently, in which he has shown very definitely that preschool training for the mentally retarded child is a very wise investment and makes the general services of the public school through special education a far better investment.

This merely underlines the need for early diagnostic services.

I would like to take just a minute to point out to you that we remain concerned about the limited services that the U.S. Office of Education can give, both by the limitation of its staffing, and by its rather unfavorable position in the echelons of the U.S. Office of Education, considering that 12½ percent of our schoolchildren are in the ranks of the exceptional children by reason of visual defects,

hearing defects, emotional and social problems, mentally retarded, and others, altogether 5 million schoolchildren.

This office is woefully understaffed, and it is a very serious matter because as we develop new services it is of the essence that we have an office on the Federal level which can make available new knowledge to the States which can stimulate action, which can follow through, which can coordinate, and we feel very strongly that the very devoted and inspired service the staff has given so far certainly ought to be increased by addition, by strengthening of this particular arm of our Federal Government.

This is particularly necessary as we are developing better programs in the field of vocational rehabilitation.

We now have several school systems that in some way or other on the secondary level are providing educational training for retarded youngsters.

Here I come right back to what Dr. Boggs said, an ever-increasing need, for instance, for dovetailing between the public school services which, as I say, on the secondary level for retarded youngsters go into vocational training, some prevocational preparation, as a lead into the realm of the Office of Vocational Rehabilitation with specific sheltered workshops, vocational training, and programs, and so on.

Certainly for that we ought to have adequate staffing to bring about the constructive dovetailing to which she referred.

I would like to make one brief mention about H.R. 3465, for which we are so grateful to you, Mr. Elliott, and would like to address myself here only to title II, the independent living provisions.

Certainly we most definitely support the other provisions pertaining to workshops, rehabilitation facilities, and the evaluation services. But we feel that there is a need to stress the significance of this independent living part in title II.

We are aware that here you and your committee have really moved far ahead and are so considerably advanced that perhaps some people are not yet fully understanding the significance.

We realize and we know that these provisions, of course, are not just dealing merely with the severely retarded, but with other severely handicapped, though we can speak perhaps more definitely about our own field.

We realize that so much of the knowledge that we have gained in recent years about the more severely mentally retarded is as yet not common knowledge even among professional people.

So we have a good deal of misunderstanding.

We feel, on the other hand, that the very interesting study Dr. Sanger did in New York State for the interdepartmental health resources board has certainly shown that in spite of what we have not done for mentally retarded, a large number of them, of the severely mentally retarded, do exist and do live in our community, and certainly with the services provided for in title II of H.R. 3465 we can do a great deal more for them.

We are convinced that we cannot limit ourselves when we speak of the worthwhileness of the economy of programs for the mentally retarded in the field of vocational rehabilitation, that we cannot limit ourselves merely to those where we actually get in sheltered workshops or on the job some productive results, because you also have to take

into consideration the very considerable drain on family resources when the severely retarded are at home, either as full bed patients or else in a high degree of dependency, which calls for continual service by the family.

If, under the provisions of this bill, and certainly we know that it can be done, a so-called permanent bed patient can get services which enable him to be ambulant, whenever another person through such services can learn to take care of his bodily needs, when a third person can learn to lessen his total dependency and become helpful around the house, this, while it cannot be spelled out in wages earned, nevertheless, means a very considerable relief to the family and very often a relief that can be estimated as a definite economic aid of the family.

We feel that the independent living provisions are of tremendous importance, and we do hope most sincerely that your committee will continue to support them.

We are aware that there have been some questions about them, and we are also aware that there are still people who feel that the entire group which is referred to as trainable children and who formerly were characterized as with an IQ of under 50, really all should be lumped together as individuals who have severe limitations in terms of being helped.

We would feel very strongly that, through the independent living facilities, some individuals actually will be enabled eventually to move on into some public schooling; individuals who are particularly handicapped bodily, and this bodily handicap together with the mental handicap is just too much for them at that moment.

But with help, through these services, this can be overcome.

For that reason, we feel that really H.R. 3465 will be as much a landmark for the severely retarded as the Public Law 113 of 1943 was a landmark in the development of the total services for the mentally retarded.

Thank you very much.

Mr. ELLIOTT. Thank you, Dr. Dybward; and thank you, Dr. Boggs. We appreciate your testimony very much.

(The formal statements of the foregoing witnesses follow:)

TESTIMONY OF DR. ELIZABETH M. BOGGS, PRESIDENT, NATIONAL ASSOCIATION FOR RETARDED CHILDREN, INC.

THE NEEDS OF THE MENTALLY RETARDED

Special education and rehabilitation services are central to the interests of the National Association for Retarded Children, which devotes itself to promoting the welfare of America's estimated 5 million mentally retarded citizens of all ages and all degrees of disability, wherever they may be. The condition of mental retardation originates before, during, or soon after birth and, once established, cannot be cured in a medical sense; it can, however, be ameliorated by training and by appropriate manipulation of the environment, especially during the formative years—hence our deep concern with the purposes of the current study.

The mentally retarded person is a citizen with certain special needs; he is also a citizen with rights as an individual and as a member of society. Too often in the past we have spoken grandly of "all children," but in a footnote have made an exception of the mentally retarded child. He, too, must have access to "opportunities for children and youth to realize their full potential for a creative life in freedom and dignity," along with all the others for whom this theme is being invoked during 1960 in connection with the Golden Anniversary White House Conference on Children and Youth. Likewise, the mentally retarded

adult must be given the opportunity to find his niche in the social and economic life of the Nation to the extent of his ability, and must be offered that measure of protection, ranging from slight to maximal, which the degree of his disability warrants.

As to all children and youth, society's first obligation to the retarded youngster is to strengthen him physically, emotionally, intellectually, and spiritually to the fullest possible extent. We do this out of our democratic respect for the worth of each individual, and we do it out of our conviction that no human resource should be wasted and no individual considered expendable.

THE ROLE OF THE FAMILY

In the National Association for Retarded Children we have given much thought to the mutual responsibilities of the retarded individual, his family, his community, and his government.

The duty of the retarded child and adult is simply stated: It is to do his best to use the opportunities presented to him, to learn from the world about him, to care for himself, to respect the rights of others, and to make whatever contribution he can to the general weal of family, community, State, and Nation.

We in NARC also believe firmly in the same family responsibility to the handicapped child as to the normal child. We believe, however, that this responsibility can only be properly discharged in an atmosphere of community acceptance and with the aid of community-sustained services—services some of which will parallel those available to all families and all children, and some of which must, by the nature of things, be of a special character. To the family of a normal child there is available today, as a matter of course and a matter of right, the supporting efforts of churches, schools, health services, community recreation programs and the like. Yet even these common social benefits have frequently been denied to the retarded child and adult and his family. In the area of special services, society's efforts have been spasmodic, ill planned, incomplete, and, hence, doubly costly.

THE ROLE OF THE VOLUNTEER AGENCY

In a free society, citizens have a responsibility to help themselves and each other; the volunteer agency has become the vehicle for such citizen action.

Through its 700 local member units, banded together in 47 State associations, NARC is providing direct services to many thousands of retarded children and adults. These services include diagnostic clinics, parent guidance, nursery schools, day-care centers, day schools, day and resident camps, swimming programs, teenage canteens, vocational counseling and placement, vocational and social rehabilitation centers, sheltered workshops, activity groups for severely retarded adults, and volunteer services in institutions. (More than half the sheltered workshops for the retarded in this country appear to be operated by units of NARC, who act as agents of the State and Federal program.)

NARC has also stimulated hundreds of other agencies, public and private, to assume their own proper responsibility for similar services to the retarded. We regard our direct services in most cases as demonstrations—a way of showing that there are retarded children and adults not now being served and that they can be helped. Ours is also an emergency service; time is running out for many youngsters, while legislators debate and school boards hesitate.

The voluntary agency has the opportunity to lead the way, to respond quickly to newly felt needs, to experiment and demonstrate, to make patent the areas where Government action will be required.

THE ROLE OF GOVERNMENT

What then is the role of Government? Fundamentally we would feel that there is an obligation on each agency of Government to provide to the mentally retarded those services they need which the agency has already been mandated to provide for all children and adults. Let the concept of free public education for "all the children of all the people" include the mentally retarded child. Let aid to dependent children not exclude aid to the dependent retarded child. Let the crippled children's commission know that the crippled retarded child is no less entitled to physical or speech therapy. Let the public health nurse be no

less concerned that the retarded child be immunized, well nourished, or promptly hospitalized. Let the rehabilitation agency think also in terms of a prosthesis for the mind. Let it also not refuse its services to the eligible residents of public institutions for the mentally retarded. And, last but not least, let the employment agencies extend their staffs and services to provide for the mentally retarded, qualified to seek jobs on the open labor markets.

Above and beyond the recognition that the handicapped is a person and a citizen, Government has a responsibility to take cognizance of the special impediments characteristic of the handicapped. From the point of view of the individual and his family it is right that some share of the burden of extraordinary misfortune should be lifted through social action, through service rendered at common expense. Of equal importance is the obligation of Government to advance the common welfare by contributing to the prevention, where possible, and to the mitigation, in any event, of all forms of disability which impair social usefulness or lead to dependency. It is this latter principle which has provided primary justification for the entire remarkable State-Federal vocational rehabilitation program. We endorse the extensions of this principle incorporated in the pending bills on rehabilitation (H.R. 3465 and S. 772) and urge that the language of these bills be clarified so as to insure that the intent covers the more severely mentally handicapped.

Recognizing the dual-faceted responsibility of government to concern itself with the handicapped individual as a person, and as one whose special problem is a social concern, we may address ourselves to the proper division of the responsibility as between local (or county), State and Federal levels. Most students of government seem to accept the thesis that services should be rendered at the most immediate (lowest) level at which they can be efficiently performed. In this country direct services, even to the handicapped, are rarely rendered by the Federal Government. The distribution within any particular State of this responsibility for direct services, through schools, vocational counseling, hospitals, etc., will reflect localized socio-economic, political, and historical factors, and is of secondary concern to this, your committee.

The responsibility of the Federal Government for service, while indirect, is nevertheless, highly significant. In an age of high mobility the Federal Government must, of course, be concerned that a certain minimum level of dependency prevention be practiced in all States lest those States which address themselves conscientiously to this subject inherit the human and economic costs of those who do not. Stimulation of State government agencies to the proper performance of their direct service tasks has become in the last decade or two a particularly significant and proper part of the Federal program, especially in the fields of health and welfare. Again the vocational rehabilitation program is an excellent case in point.

The proper relation of the Federal Government to the State-controlled public school system has been the subject of controversy. On the general question of Federal aid to elementary and secondary education we take no stand, except to say that whatever form such aid may take should assure that the exceptional child is by it no less well-served than the normal. Our position on the subject of eligibility for Federal surplus property is an example. The U.S. Office of Education in its accepted role must serve the handicapped as well as the average child. It is imperative that the Commissioner of Education and the Section on Exceptional Children and Youth be better equipped to carry out obligations to special education. Our executive director, Dr. Gunnar Dybwad, will address himself to this concern.

PROFESSIONAL TRAINING AND RESEARCH

A more direct role for the Federal Government in promoting opportunities for professional education in professions where shortages threaten the well-being of the Nation has now been established, and, in recent years, extended with widespread popular and congressional support. Likewise the cognate function of research has been recognized as an activity in which the Federal Government is a proper partner. There are aspects of both activities which by their nature transcend local boundaries and yield only to national leadership. In the last 5 years the Congress has thoughtfully made available both to the Office of Education and to the Office of Vocational Rehabilitation funds for research and

professional training pertaining specifically to education and rehabilitation of the mentally retarded. These programs are quite new and it is to be expected that there must be a period of administrative experimentation in determining the optimum manner in which these funds may be deployed to accomplish the purposes intended by the Congress.

In the Federal vocational rehabilitation program, the research and training programs are generic to the entire field of the handicapped, and we must bespeak our appreciation both to the staff of the OVR and to the Congress that the mentally retarded have in recent years begun to come into their own within this larger context. In the cooperative research program of the Office of Education also we find a needed emphasis on the mentally retarded, coupled with grants pertaining to other areas of exceptionality as well as to education in general. Only in professional preparation in the field of education do we see a statutory emphasis placing undue restriction on a subject area. Here your committee may wish to consider further statutory changes; in line with the position which we have taken throughout the history of the passage of Public Law 85-926 (for which we are so grateful to several members of this very committee) we respectfully submit that as soon as adequate experience with the present 1958 statute has provided a basis for evaluation, the legislation should be extended to cover the preparation of personnel qualified for advanced work and leadership in other branches of special education, more particularly the education of the physically and neurologically handicapped and the emotionally disturbed.

The act Public Law 83-531, in which the cooperative research in education programs is being carried out, does not explicitly provide for the training of personnel for research in this field, nor does Public Law 85-926. This is a defect which should be remedied since we can soon exhaust our scant reserves of qualified investigators in these fields.

Another defect in the language of the cooperative research act stems from an understandable but regrettable lack of appreciation of the role of the residential school and institution in the network of special education and rehabilitation. These facilities—and for the mentally retarded alone there are currently 103 public residential institutions—offer certain unique opportunities for both research and professional training, as well as for direct service. It should be possible for such institutions, if equipped and qualified, to apply for and receive Federal grants for research and, where appropriate, for professional training, in any relevant subject area, especially where the benefits of such activities can be expected to benefit significantly the handicapped beyond the borders of the State in question. There is reason to believe that latitude in selecting the recipient institution allowed in the State governing the NIH programs, is best suited to accomplish the basic missions in professional development and research.

What we have heard in attending hearings conducted by this and other committees and what we have inferred from conversations with Congressmen leads us to believe that congressional intent in respect to professional training and research, does focus, as we believe it should, primarily on doing those things which the States cannot severally do for themselves, rather than on those things which some States have heretofore failed to get around to doing. We hope that the Congress, in reviewing these programs in the future, in modifying them through increased but selective appropriations, and in encouraging the executive branch, will continue to make clear that both in research and in advanced professional training a long-range approach is needed. The needs of these two areas must be viewed in national perspective; the resources of the Nation must be marshaled and cultivated in those places where they can best flourish. Potential leaders in the field must be selected from among the most gifted candidates regardless of geographic origin. They must receive the most rigorous, most modern, and most inspired preparation wherever available, and then must be most rapidly deployed across the Nation to the points where they are most needed.

Through efficient Federal participation in programs of professional training and research in the fields of special education and vocational rehabilitation we can do much to rescue the handicapped, of which the mentally retarded constitutes such a major portion, from personal futility and social dependency. To do so is to serve the national interest.

DECADE OF DECISION—AN EVALUATION REPORT PREPARED BY NATIONAL ASSOCIATION FOR RETARDED CHILDREN, INC., FOR THE 1960 WHITE HOUSE CONFERENCE ON CHILDREN AND YOUTH

I. PREAMBLE

The year 1960 will be celebrated as the 10th anniversary of the National Association for Retarded Children. The birth and rapid growth of NARC is thus in itself one of the phenomena peculiar to the decade under review; it is a phenomenon which significantly affects the lives of the nearly 2 million children and youth of the United States who are mentally retarded in greater or less degree.

NARC has been both a producer and a product of changed attitudes toward mental retardation. It was created to promote the welfare of the mentally retarded of all ages and degrees of handicap wherever they might be and to develop the means of preventing this condition in children of the future. It is the only national voluntary citizen organization espousing these objectives.

II. HOW NARC CAME INTO BEING

The movement on behalf of retarded children had its slow beginnings in the mid-1930's with the formation of a few localized groups in Ohio and Washington. The national association was organized in September of 1950 when 40 individuals, representing local associations in 13 States, assembled in Minneapolis and adopted a constitution under which the National Association of Parents and Friends of Mentally Retarded Children came formally into being in February 1951, after ratification by the first 20 existing local associations. Despite differences in organizational structure and immediate goals these pre-existing groups were impelled by their basic common purposes.

By the time of the 1951 convention the following October, 57 local associations had adhered to the new federation. By September 1959, the organization had grown to 700 local member units distributed in 49 States (Alaska being the only exception) and having an individual membership of approximately 50,000 individuals. State federations have been formed in 46 States. Of the 170 standard metropolitan areas listed by the U.S. Census Bureau, only 11 are not directly served by 1 or more units of the NARC. Hundreds of smaller associations reach out into the farm communities of Iowa and the mountain valleys of Idaho and upland California and the outlying islands of the Hawaiian Islands. Member units have also been formed in overseas military installations.

Comparable organizations are developing apace in most of the countries of the British Commonwealth and in Norway, Sweden, Denmark, Holland, France, Switzerland, Israel, and Japan. An international federation is almost certain to be formed within the next decade.

III. WHY NARC AT MIDCENTURY

In view of the stress being laid by the 1960 White House Conference planners on social, cultural, and economic changes, it may be appropriate to explore here briefly the question, "Why did a parent-inspired national voluntary movement in behalf of America's retarded children and adults emerge when it did?" The half century between 1870 and 1920 was, in fact, a fertile one both scientifically and socially for the mentally retarded. The first public school class for the mentally retarded was opened in Providence in 1896, and the special class had become an accepted and established part of many of the major city school systems by 1920. Residential institutions for care and training were established or expanded in many States during the same period. The scientific study of the behavior of the mentally retarded flourished. Partly because of the high mortality of the most severely handicapped, scientific and social attention focused particularly on the mildly retarded. Both science and society "discovered the moron" in the year of the first White House Conference but whereas science reacted on the whole with constructive curiosity, society, on the other hand, tended to react with something less than constructive anxiety to the new "menace", an anxiety which resulted in ill-founded enthusiasm for programs of segregation and sterilization. The schools, however, remained faithful through the third decade, and programs continued to spread. This era appears to have come to its climax in 1930 when the rights of the handicapped child to education

were set forth in the voluminous publications of the 1930 White House Conference, whose findings were still being quoted in college lecture halls 25 years later. Even such dedication was not proof against the combined effects of the depression and the staggering increase in total school population of the 1930's. From the mid-1930's on, enrollment of mentally retarded pupils in special classes declined not only absolutely, but also proportionately until the late 1940's.

Somewhere along the line also, the inclusiveness which had characterized the school programs of the first quarter of the century began to be modified. Sometimes by law, sometimes by interpretation, sometimes just by gentlemen's agreement among administrators, special classes for the mentally retarded began to be restricted to those defined as "educable," usually designated as IQ 50 or above.

Soon also, child guidance clinics established earlier in a number of States, primarily for the purpose of helping the mentally retarded, began to turn their attention away from the retarded favoring now the emotionally disturbed, for whom the new psychiatry seemed to offer more results. The edge began to off the hope of the first quarter century.

In the meantime the hospitals, the obstetricians, the pediatricians, and the other maternal and child health workers had been collaborating to produce spectacular reductions in infant mortality. The introduction of antibiotics immediately following World War II saved additional young children from respiratory and gastrointestinal diseases. These improvements in public health appear to have differentially favored children with congenital handicaps such as mongolism. These trends, superimposed upon the high postwar birth rate, brought us to the opening of the second half century with a significantly larger number of young, severely mentally retarded children, both numerically and proportionately, than at any time in our previous history.

The majority of these more handicapped youngsters were "trainable," i.e. capable of profiting by a modified program of group instruction slanted toward goals of social adjustment and the development of language and manual skills. Yet, with the exception of three or four isolated cities and a few smaller communities, these children were being rejected right and left by the public schools.

Parents of those who were too severely retarded or had complicating disabilities precluding classroom participation were being almost universally advised by physicians to place their children in residential facilities only to find that thousands of other children were already enrolled on waiting lists ahead of them. Because of the high costs of long-term residential care, 90 to 95 percent of families must seek it in a public institution. Parents whose children had secured admission to one of the State-operated "schools" or "homes" housing anywhere from 500 to 5,000 individuals of almost all ages, were often shocked at the overcrowding, understaffing, poor maintenance, minimal food, and unsanitary conditions not to mention the enforced inactivity of the majority of "patients" which did nothing to enhance the "freedom and dignity" of the handicapped child and little more for those who, in spite of everything, might be struggling to care for him.

War, depression, and, paradoxically, modern medicine had conspired to bring about an acute multifaceted social crisis to which the social response was the formation of a community-based, State, and nationally coordinated movement. This movement, on behalf of the "forgotten children," already somewhat overdue, having been itself inhibited by conditions prevailing between 1935 and 1945, flowered readily in the relatively more favorable environment of the last decade. Perhaps it was not coincidence that it was born in the year of the midcentury White House Conference, with its emphasis on citizen participation. Although still relatively modestly financed, especially in relation to the size of its task, when compared with other major voluntary health and welfare organizations, NARC has, nevertheless, come of age and come to stay in 9 breathless years.

IV. RELATION OF NARC PROGRAM TO CONFERENCE THEME

By focusing on "opportunities for children and youth to realize their full potential for a creative life in freedom and dignity" the national committee has focused on an issue which is not only germane, but central to the interests to NARC, most of whose activities are directed toward creating such opportunities for the mentally retarded.

1. *Values and ideals*

Our society is not always entirely consistent in applying its values and ideals to the mentally retarded. On the one hand, we affirm the value of each individual, his right to individual fulfillment and to a useful social role in accordance with his abilities; on the other hand, stress is placed on economic and scholastic achievement, physical agility, and perfection in competition in feats in which the mentally retarded can seldom emerge triumphant. We are still asking the retarded child to value himself and value a society which too often devalues him. ("Why should we spend money on the retarded when we are not doing enough for the gifted?" or, "Of course the retarded youngsters should have their school, but not in our neighborhood.")

2. *Effects of change*

By the very nature of his handicap the retarded child is slow to adapt to changed circumstances, sometimes slow even to perceive that they have changed. The problems presented by mobility, urbanization, uncertainty as to acceptable mores, may all confront the retarded child in exaggerated form. Two characteristic effects are worth special mention: (a) since the retarded individual must be prepared more explicitly for his occupational future, he will be especially vulnerable to changes in the structure of available employment to the extent that these cannot be foreseen by his teachers; (b) servicemen's families and other highly mobile parents are confronted with a particularly difficult task of providing continuity of programming for their handicapped children and also of securing those services to which there are residence laws applying.

3. *Personal and environmental influences*

Since with present knowledge little can be done to cure or treat the condition of mental retardation once established, it is to the manipulation of personal and environmental influences on retarded children and youth that the NARC directs a major part of its program, which will be analyzed according to the suggested components in the following section.

V. THE NARC PROGRAM 1950-60—PART A: "TO PROMOTE THE WELFARE OF THE MENTALLY RETARDED"

It may be worth noting that NARC's program of service to the retarded has changed shape somewhat in the decade; it started out as comprehensive but somewhat elliptical, polarized around the two focuses of needed day schooling and equally needed residential care facilities. By 1954 it had become decagonal, with the emergence of a 10-point plan, but by 1958 it had taken on the holistic simplicity of a well-rounded program.

In any case, mental retardation being all pervasive in its influence on the life of the individual, the mission of NARC encompasses the family, religion, health, education, recreation, welfare, law and government, work, and guidance. A definitive evaluation of the accomplishments of the last 10 years and tasks yet to be accomplished in each of these areas would require a volume. The more there is to be done the less time there is to write of it. Therefore, only selected highlights are outlined below, as indicative of trends. These have been chosen without regard to the wellsprings of action. NARC may serve directly or it may serve as well by creating the environment in which others may achieve; it is to the program objectives rather than authorship that we address this evaluation.

A. *The family*

Accomplishments for the family.—1. Physicians' advice: Reports from parents at the time of the formation of NARC, while not quantifiable, indicate that it was common practice among physicians at that time to couple a diagnosis of mental retardation with advice to institutionalize the child promptly. This advice was often given without consideration of its practicability or of the responsibility of the parents to evaluate and decide for themselves. One of the hopeful signs of the last decade has been the increasing frequency with which articles have appeared in professional journals, including medical journals, advocating a more individualized approach and in particular inveighing against advice to institutionalize in infancy or early childhood except in extraordinary circumstances.

2. **Diagnosis and guidance:** The family who suspects one of its children of being mentally retarded needs a comprehensive coordinated evaluation of the medical, psychological, social, and educational factors, interpreted to the parents in language and at a pace they can understand, coupled with practical suggestions for the care and training of the child related to actual, available resources. To be properly effective such a service must be rendered by specialists who have a major interest in the retarded child and a specialized knowledge of his problems. There is not known to our association any facility in existence prior to 1949 which met all of these criteria. The development of such clinical facilities in the past decade is indicated by the following:

Date:	<i>Number of clinics</i>
Jan. 1, 1949-----	0
Jan. 1, 1955-----	33
Jan. 1, 1959-----	70

The first clinics were initiated for the most part at the urging of local associations for retarded children, but the second and more difficult half of this development owes much to the special grant program of the U.S. Children's Bureau.

3. **Parent education:** In 1950 a most serious problem facing parents of retarded children was the lack of helpful information on the problem of mental retardation and particularly on home care and management. Since then many communities have developed parent education programs. In a recent survey NARC found a distinct trend toward parent-motivated discussion groups (as opposed to lectures), with 44 out of the 75 programs providing for series of 6 or more meetings.

4. **Parent education literature:** The editor of a reading list for parents in 1950 found only two pamphlets (one of them Canadian) and one chapter of a book addressed directly to the parents of retarded children. NARC's 1959 revision of "Windows of Understanding," its reading list for "new" parents, lists 18 books and pamphlets written expressly for parents of the retarded, together with 5 book-length, first-person stories.

5. **Studies of family living with retarded:** Although in 1950 brief generalized statements in psychiatric textbooks about the disintegrating effect of a mentally retarded child upon his parents and siblings were quite common, no substantial research had been done on this problem. In 1959 a monograph based on a 3-year study entitled "Effects of a Severely Mentally Retarded Child on Family Integration" was published, which among other things indicated the inappropriateness of unqualified generalizations.

6. **Peer groups:** Increasingly, reports received from NARC State and local units, reveal the role being played by normal youth in molding the environmental influences on the retarded young person. Youthful volunteers help to staff day and residential camps, participate in teenage canteens for the retarded, help to raise funds, write term papers, or give talks before social studies classes and finally elect careers of service related to mental retardation. There is no doubt that these young people, shorn of prejudice as they are, or as they become, bring to the retarded with whom they come in personal contact a particular kind of reassurance.

Tasks ahead in relation to the family.—1. Bringing comprehensive competent evaluation and guidance services to parents in rural areas.

2. Modifying the content of outdated high school texts in social studies, which by purveying unscientific ideas prejudicial to the mentally retarded, not only cause pain to their adolescent siblings, but also sow the seeds of unnecessary shock and shame for those youth who will shortly become the parents of the mentally retarded children of the next decade.

B. Religion

Accomplishments in the field of religion.—In 1952 NARC sought from the major national bodies concerned with religious education of children, help and guidance in providing suitable instruction for the mentally retarded of varying degrees of intellectual limitation. Little or nothing was to be had. By 1959 we find throughout the country hundreds of classes through which Roman Catholic, Protestant, and Jewish children are instructed in the essential truths of their faith. The National Catholic Education Association established its department of special education, and the National Council of Churches issued several publications stressing the churches' responsibility to the handicapped, including the

mentally retarded. Institutes for religious teachers and for clergymen have been held in various parts of the country; books are appearing in which the role of religion in the life of the retarded child and his family are discussed, new day and residential schools, usually nonsectarian in admission policy, are being organized under Roman Catholic, Lutheran, Presbyterian, Episcopalian, Jewish, and other auspices.

Tasks ahead for religion.—1. Development of really appropriate instructional materials for use with mentally retarded children.

2. Better preparation of clergymen of all faiths to meet the spiritual needs of the families of the retarded.

3. Cooperation of the religious bodies and government in meeting more adequately the religious needs of the institutionalized retardate.

C. Physical health

Accomplishments in physical health.—1. At the beginning of the decade children with orthopedic handicaps who were also mentally retarded were frequently excluded from crippled children's services. Substantial improvement has been noted. (More precise documentation is available from U.S. Children's Bureau.)

2. Pediatric internships in facilities caring for the mentally retarded have substantially increased during this decade.

3. In 1950 there were few dentists prepared to accept and treat a severely involved mentally retarded child who could not cooperate. Extraction was often the only kind of dental treatment offered. During the past 10 years special institutes for dentists have been held and a number of specialized dental clinics established.

4. Public health nurses have become increasingly aware of the role that they can play in assisting the family of a young mentally retarded child to train him in feeding, dressing and toileting.

5. A conference on nutrition of the retarded institutions was supported by the Children's Bureau.

6. Prevention of brain damage by early intervention with special surgery, special diets and other means is becoming recognized as a responsibility of the physician.

Tasks ahead in physical health.—1. While certainly diminishing, there is still a substantial number of physicians who consciously or unconsciously reject the retarded child, as a patient whose physical well-being is not fully worthy of their attention. This is probably a matter of medical education.

2. The handling of the severely retarded child who is hospitalized has been little studied and the insecurity of nurses faced with this problem often compounds an already difficult situation.

D. Mental health

Accomplishments in mental health.—1. Probably the most significant contribution to the mental health of the mentally retarded child has been made by NARC itself through public education and through the opportunity which it affords to parents to associate together and share experiences. The self-respect and self-confidence thus engendered in parents, together with the provision of practical services by the communities, local and State, made possible better overall mental health for the mentally retarded.

2. In 1950 mentally retarded individuals, even of the higher ranges of intelligence were frequently rejected for treatment by mental health clinics and private practitioners on the assumption that they could not benefit by psychotherapy. During this decade these attitudes have substantially changed, as evidenced by the wide circulation of such books as "Psychological Problems in Mental Deficiency" (Sarason) and "Counseling and Psychotherapy With the Mentally Retarded" (DeMartino). (In 1957 the regional office for Europe of the WHO sponsored a 10-day seminar devoted entirely to the mental health of the mentally subnormal child.)

Tasks ahead in mental health.—1. Although mental deficiency has been traditionally assigned by medicine to the domain of psychiatry, few psychiatrists are adequately trained in the intricacies of this complex field.

2. The frequent categorization of mental retardation as "a mental health problem" by laymen and professionals alike, has inhibited other specialists from recognizing and assuming their proper responsibilities. (Example, a State department of health which replies to a questionnaire on its services to the mentally retarded by stating categorically that the State department of mental hygiene "takes care of everything.")

E. Education

Accomplishments in education.—Short of primary prevention, education offers the greatest hope for the mentally retarded. Progress during this decade has been spectacular.

1. In 1949, 24 States and the District of Columbia had State legislation providing for special classes for the mentally retarded in the public schools. In 1959, 48 States and the District of Columbia had such legislation. (States without legislation are Arizona and Alaska, of which the former had classes in several major cities.)

2. In 1950 no State had laws specifically encouraging local districts to provide for the "trainable" mentally retarded (roughly characterized by IQ 25 to 50), although a few States tolerated and even subsidized such local classes as might be initiated by local school boards under general, broad-purpose legislation. By 1959, 20 States had specific mandatory or permissive legislation under which such children are provided for in the local public schools. An additional 17 States by administrative regulation or interpretation sanction such classes as being authorized under more general laws.

Laws do not create classes by themselves, however. The following table gives a rough gauge of progress.

Public school enrollment of mentally retarded in special classes

	1940	1948	1953	1958 ¹
Educable.....	(2)	(2)	109,903	-----
Trainable.....	(2)	(2)	4,662	-----
Total.....	98,416	87,030	113,565	-----
Percent of total public school enrollment.....	0.38	0.36	0.39	-----

¹ To be filled in from USOE figures about to be released.

² Not differentiated.

3. During the decade an important study of teacher preparation was made by the U.S. Office of Education. It revealed that in 1954 40 colleges and universities were offering a sequence of at least 3 courses including supervised practice teaching to prepare teachers of the mentally retarded. Since then the number of such curriculums has substantially increased and summer sessions have become very widely available indeed.

4. An analysis of the current and projected need for teachers of the mentally retarded was made by NARC in 1956 and submitted to the congressional committees considering the bill which, in 1958, became Public Law 85-926, and has now been activated by means of an appropriation. Its purpose is to encourage expansion of education of mentally retarded children through grants to institutions of higher learning and State educational agencies to improve and increase the training of personnel.

5. Extending school programs accentuates the need for further research in techniques and substance of education for the retarded. The inauguration of the cooperative research program under the U.S. Office of Education in 1955, with the earmarking of a substantial fraction of the funds for research in the education of the mentally retarded, is another significant accomplishment of this decade.

6. Nursery schools for preschool children and day care centers for children too severely retarded to qualify for program of public school instruction are part of the larger education picture designed to permit each mentally retarded child to achieve his full potential, however limited. NARC is currently surveying the rapid developments in this field.

Tasks ahead in education.—1. Finding more effective ways of reaching the extremely severely retarded child on an individual (nonschool) basis.

2. Better financing of special classes in States which have been slow starters.

3. Greater reciprocity among States in teacher certification standards, which in turn would imply a raising of the standards in many States.

4. Improved coordination between education and vocational rehabilitation agencies in preparing the mentally retarded for the world of work.

5. Emphasis on quality in teacher preparation based on depth and breadth in this special competence on the part of college faculty members.

6. Better orientation of education administrators to the goals and uses of the special class.

F. Recreation and the arts

Accomplishments in recreation and the arts.—1. So far as is known the first summer day camp for mentally retarded children was organized in 1950. By 1955 there were 55 such day camps; in 1959, 150 were reported. A number of residential camp programs have also been established.

2. A cooperative effort between NARC and the National Recreation Association revealed that between 1954 and 1958 the number of recreation programs, such as summer playgrounds, teenage canteens, and swimming activities, sponsored by municipal public recreation departments at least treble.

3. A manual on swimming for the retarded was prepared in cooperation with the American Red Cross water safety director.

4. Although Boy Scout troops in residential institutions date back to the late twenties, it is believed that the first troop of retarded scouts in the community was formed in 1950. Now 150 troops of mentally retarded boys (including cubs) are registered with the Boy Scouts of America. Comparable advances in girl scouting are recorded.

5. In the spring of 1959 a Milwaukee museum devoted an entire exhibition to art of the mentally retarded.

Tasks ahead in recreation and the arts.—1. Orientation of recreation workers and directors to the place of the retarded in community recreation programs, and particularly to the factors which determine the extent to which any particular child should be integrated with or segregated from normal children in group activities.

2. Research on safety in recreation for the retarded—in design of equipment and of activities.

3. Analysis of recreational activities and needs of retarded adults of various levels as a guide to the recreation skills and presences which they should be encouraged to develop as children.

4. Development of recreational activities appropriate to very severely retarded children in the home, in community centers, and in institutions.

G. Welfare

Accomplishments in welfare.—1. Casework: Perhaps no where more than in the field of welfare have we seen the philosophy of segregation of the retarded reflected, not merely in arrangements for his physical isolation but also in the administrative structures of State and local government. It seems that the retardate must either be capable of being treated as a "person" whose problems can be dealt with by a welfare worker with a "generic" approach, or else the agency should wash its hands of him and turn him over to "the people in charge of institutions." If the institutional agency finds it either undesirable or impossible to institutionalize the child, it will presumably have to set up its own foster home or other supervisional program. With the outstanding exception of Minnesota, whose community program for the retarded was born within its child welfare services 40 years ago and managed to survive the dark ages of the second quarter century, the attitude of "let the institution do; it's their job" seems to have been prevalent in child and public welfare agencies, wherever substantial services beyond financial grants were seen as necessary. It is therefore significant that, during the last decade—

A specialist in mental retardation was placed on the staff of the child welfare section of the U.S. Children's Bureau.

The Children's Bureau initiated a study of the prevalence of mental retardation in the case load of public welfare agencies.

The National Conference on Social Welfare of 1959 included four sessions dealing specifically with problems of the mentally retarded.

A number of caseworkers have publicly deplored the inadequacy of their professional orientation toward problems of the retarded.

2. Social security amendments: Of great importance to the dependent retarded youth and his family were the 1956 amendments to the Social Security Act which extended survivors' benefits to a permanently disabled child beyond the age of 18.

3. Residential care: State governments are now paying over \$200 million a year for the care of approximately 150,000 mentally retarded or epileptic individuals in public institutions. In 1950, 46,000 or about 37 percent of those

then in institutions were under 21; the proportion as well as the gross has undoubtedly increased in the past decade, since a general trend to earlier admissions of more severely retarded children has been noted. Between 1950 and 1957 public institutional capacity for the retarded increased by approximately 10,000 beds. Although accurate statistics on waiting lists on a nationwide basis are not presently available, it appears that new building has merely kept up with demand without substantially decreasing the backlog. (At middecade there were between 10,000 and 15,000 retardates awaiting admission.) Space is most acutely needed for severely retarded young children at the present time. Although some 17 new institutions were created during the decade (with 6 more on the boards), leaving Nevada and Alaska as the only States without separate State operated residential facilities for the retarded, too much of the new capacity was achieved by enlarging already overly large institutions.

There has been considerable experimentation with building design. One State sent its architect, a professional educator, and a member of the legislature on a nationwide tour to look at new buildings and consult with those administering residential programs, prior to drawing up plans for a new institution. Despite interest and talk, however, basic philosophical concepts are still confused; there is still inadequate differentiation between the needs of the higher grade individuals for whom the institutional training program is a way station on the way back into society, and the severely retarded for whom it may have to be a permanent way of life; there is inadequate communications between architects, superintendents, people who actually work in the buildings, and experts in heating, lighting, mass feeding, communication systems and other specialists in the logistics of the physical management of institutions. (Superintendents are usually physicians or educators.) Ways in which building design can minimize housekeeping and thus maximize the amount of time that attendants can spend caring for the social and emotional needs of children have not been fully analyzed.

Programing has undoubtedly improved in the majority of institutions, although not spectacularly, during the decade. Of the approximately 27,000 educable and trainable children of school age in residential institutions in the early part of the decade, only about 22 percent were enrolled in educational programs, notwithstanding the fact that the opportunities for education are often held out as a principal argument for removing such children from their homes. For comparative figures we must await the 1960 national census, but one can infer, from such indirect information as the increase in the number of teachers employed by institutions, that educational programs therein are being expanded. Recreational activities are also improving, as have medical and psychiatric care and social service.

Relations with parents, individually and collectively, have undergone significant and recognizable changes in most States. Most institutions for the mentally retarded have been primarily "open institutions" in the sense that they are not walled or barred. (There are some deplorable exceptions.) Today, however, they are opening inward as well as outward as the frequency of visiting by parents and citizens increases. The development of volunteer service programs within institutions for the mentally retarded constitutes another important advance during the decade.

The period 1950-60 has seen the advent of both tranquilizers and TV in most institutions, on the whole for the better, although not without certain attendant hazards for those who mostly sit and wait.

The decade has also seen considerable agitation for the reform of the various State systems of charges to parents for the care of their minor and adult children in residential institutions. Whereas most States admit any eligible child to a school for the blind, deaf, or delinquent without charge either for tuition or maintenance, in all but four States, parents are expected to pay "in accordance with their ability" up to full per capita costs for all services including education, recreation, etc. In most cases the obligation continues for life and in some States liens accumulate against the parents' estate for the difference between the maximum charge and the actual payment. Leaving aside inequities and inaccuracies in the actual administration of these laws, the basic "values and ideals" on which they appear to be based certainly require some clarification. The discrepancies are accentuated even more when one notes that in most States a parent responsibly desiring to have his child admitted to a State institution must have an order of commitment by a court, which substantially transfers legal custody if not actual guardianship to the State and leaves the parent few

legal rights in determining his child's future from that point on. At the present time the "pay plans" have been recently revised or are under active review in at least eight of the larger States.

4. Private institutions: Although there are about 200 private residential homes and schools for the retarded, housing from 5 to 500 children and adults each, these institutions account for only about 5 percent of the total institutionalized retarded population. Standard setting and accrediting of such institutions often falls in the no man's land between health, welfare, mental health, and education agencies. NARC is currently conducting a survey among the States to determine how many States have a licensing and inspection service, in what agency it is lodged, and what types of standards are used.

5. Community planning: The advent of the well-rounded or multiphase program brings with it a responsibility for local and State planning bodies, voluntary as well as official. It is heartening to note that in cities as widespread as Los Angeles, Miami, Richmond, and Chicago, for example, the local council of social agencies has initiated an objective look at the totality of services available from specialized and general purpose agencies to the retarded children, youth, and adults of its community.

Tasks ahead in welfare.—1. Action on the problem of management of the defective delinquent: The three States which have done substantially more than wring their hands about this problem (Massachusetts, New York, and Minnesota) have not come up with solutions that can be followed with confidence by others; nevertheless there is general agreement that specialized programs must be provided for the individual whose intellectual subnormality is accompanied by persistent antisocial behavior, that these individuals the majority of whom are adolescents and young adults, must be provided for, not only for their own sakes but also for the sake of those less offensive with whom they are now mingled in residential institutions.

2. Case studies of adoptive mentally retarded children—why they were adopted, under what auspices, by what kinds of people and what were the outcomes.

3. Assurances that the retarded child without parents will have the benefits of personal guardianship; provisions for competent public guardianship where suitable private guardianship is not available.

4. Projections of future need for residential care of the severely retarded based on analysis of changing trends in the characteristics of children for whom such care is sought.

5. State planning based on such projections, and on a more penetrating study of the physical and social need of the grossly handicapped, needs which, despite felicitous phrases to the contrary, differ substantially from those of ordinary human beings who can speak and act for themselves.

H. Work and guidance

Accomplishments in work and guidance.—1. World War II produced one positive result for the retarded among so many negative; it gave them a chance to show their capabilities in industry and in the Armed Forces. (It is said that the successful retarded soldier was the one who had insight into his own limitations, an important observation for those who guide them.)

2. Vocational rehabilitation of the mentally retarded as a major cooperative effort of official and voluntary agencies, local, State and National, became possible with the amendment in 1947 of the existing Federal Vocational Rehabilitation Act. While there are still some States which do not make enthusiastic use of the Federal assistance provided, the increase in the number of individuals being habilitated nationwide has been spectacular. (We do not have exact data on the number who are under 21.) This has been accomplished in the main by two types of service:

(1) Vocational counseling, with special reference to those leaving school; and

(2) The establishment of occupational training centers and sheltered workshops oriented to the needs of the mentally retarded.

3. While it is certain that a careful search of some of the multipurpose sheltered workshops of 1950 would have revealed a few high grade mentally retarded clients, those who in the early 1950's sought to lift the mentally retarded of marginal ability across the borderline from dependence to independence (or at least partial self-support) found no prototypes for what we have today. There were lessons to be learned from the workshops already

established for the blind and physically handicapped, but in most cases the personnel who had been successful with these partial disabilities found it hard to adjust to the less tangible, more pervasive and more time-consuming intellectual and social handicaps of the mentally retarded.

Today, however, NARC is in touch with at least 100 sheltered workshops and training centers for the mentally retarded which offer real resources for youth from 16 to 21, as well as for young adults. Most of these workshops receive direct or indirect assistance from State and National vocational rehabilitation agencies; 17 of them are currently conducting research or demonstration projects on Federal grants. Somewhat more than half of the known workshops and training centers which serve the mentally retarded are operated by member units of NARC, the rest by a variety of community voluntary agencies. It has been repeatedly observed in these centers that IQ is much less highly correlated with placibility in competitive employment, or productivity in the sheltered environment, than with school achievement.

Tasks ahead in work and guidance.—1. Extension of the concept of "feasibility" to permit the rehabilitation techniques developed in rehabilitation centers and workshops to reach those who would benefit by virtue of becoming less personally dependent and less of an economic burden, even though not actually capable of earning. (An individual who can feed himself is less of an economic liability than one who is not, quite aside from humane considerations.)

2. Collaboration between schools, rehabilitation agencies and social agencies in establishing realistic goals toward which the retarded youth may be systematically directed.

3. The provision of living arrangements for the retardate who can hold a job but may not be strong enough to live quite alone.

I. Law and government

Accomplishments in law and government.—Developments in this field in the past decade fall in three areas: concern with the legal status of the retarded individual before the law; examination of the structure of State services, including questions of coordination; interstate cooperation; and the development of a Federal program by major agencies of the Department of Health, Education, and Welfare, with generous support from Congress.

1. In the areas of status of the individual we note: (a) recognition (with relatively little achievement to date) of the desirability of making voluntary admission rather than court commitment the procedure of choice when care of the mentally retarded minor is sought in a State institution; (b) constructive discussion and thought concerning the rights and responsibilities of the mentally retarded who may have been engaged in or accused of criminal acts.

2. The structure of government and the need for interdepartmental coordination at the State level has been a principal or ancillary concern of at least 17 special State legislative or gubernatorial commissions appointed to review one or more major aspects of the State program for the mentally retarded. A schematic analysis was made by NARC in 1959 of the activities of those commissions which were active between 1956 and 1959.

3. Interstate cooperation was exemplified by a unique 2-day conference on State government responsibilities to the mentally retarded conducted by the Council of State Governments in November 1958.

The Interstate Compact on Mental Health developed in 1955 and now adopted by some 15 State facilitates interstate transfer of mentally retarded individuals who have been admitted to a State institution, but whose welfare would be better served in another State for some reason, such as change of family residence.

4. The establishment in the Department of Health, Education, and Welfare in 1956 of an interagency coordinating committee with Dr. Joseph Douglas as chairman, signified a major intensification of effort of the Federal Government toward stimulating and assisting State and local governments and private organizations better to serve the mentally retarded. Since the HEW is itself the best authority on its activities, it would be presumptive of NARC to elaborate on this program except to remark that its impact has been felt in every corner of the country. A significant document relating to this development is "New Directions for Mentally Retarded Children—a Report of a Conference Convened by the Josiah Macey Junior Foundation at the Request of the Interdepartmental Committee on Children and Youth and held at Princeton, N.J., February 26-29, 1956."

Tasks ahead for law and government.—1. Further basic analysis of the application and applicability to the retarded of present laws relating to "mental incompetence," guardianship of the person and property of children and adults, criminal responsibility, and commitment or detention of the retarded, from the point of view of both the principle of *parens patriae* and the principle of individual liberty and "freedom and dignity" for all children.

2. Perfection of uniform methods which can be adopted in all public agencies for recording and analyzing statistical data relating to retardation, particularly in the field of public health, welfare, and education.

3. Development of a better rationale for sharing the costs of services to the retarded as between the individual or family and society on the one hand, and as between the various levels of government on the other.

4. Research on and application of better methods of making every public dollar appropriated yield the most in service for the retarded.

VI. THE NARC PROGRAM 1950-60—PART B: PREVENTION

Perhaps it was an oversight on the part of the national committee to omit research among the list of environmental influences. Certainly in relation to mental retardation, it is a vital influence today in changing the world for children. Concerned as it is that the retarded children of today will be helped, NARC has nevertheless devoted major attention to reviewing the causes (biological, psychological, and social) of mental retardation, and counts as a major achievement of the decade the publication of the volume "Mental Subnormality" by Drs. Masland, Sarason, and Gladwin. A book reporting on a 3-year survey sponsored by NARC, it reviews the dozens of known and suspected causes of mental retardation and outlines the directions in which research should now be pursued to uncover additional causes and to effect prevention of mental retardation at its many points of origin. The pursuit of the biological causes will take scientists into almost every branch of basic medicine. From the study of psychosocial factors there emerges a clearer concept of the role of cultural, emotional, and educational deprivation, which if sustained, can permanently aggravate or even cause an irreversible depression of mental development with mental retardation at the end product. The significance of the Sarason-Gladwin section of the reports has been since underlined by the subsequent publication of the results of a 6-year study of preschoolchildren, done under the direction of Dr. Samuel A. Kirk. Kirk showed that children who are mentally retarded and who suffer the additional handicap of environmental impoverishment have a better chance for sustained school achievement if provided with a well directed preschool educational experience.

Among the landmarks in research of this decade one must also rank high the establishment and rapid growth of the National Institute of Neurological Diseases and Blindness concerned as it is with most of the basic biological causes of mental retardation.

Tasks ahead in prevention.—1. Vigorous support of research in the following principal areas in which research is important with respect to mental retardation.

Area A: Research in etiology, prevention, and treatment;

Area B: Research in accurate evaluation of the handicapped individual in mental, physical, emotional, and social spheres;

Area C: Research in the development of effective training techniques, such as would permit the individual to develop his fullest potentialities, and

Area D: Research to determine the best framework within which his teaching, training, living, and working can be most effectively carried on.

2. Additional efforts to assure that each new discovery will be applied at the earliest possible moment to the prevention of lifetime disability. During the past decade we have learned how to prevent mental retardation due to hydrocephalus, due to phenylketonuria, galactosemia and certain other specific disorders, but there are still children being lost to these diseases through lack of early detection or quick availability of prevention measures. Prevention of mental retardation due to psychosocial factors will be still more difficult, but a beginning could be made by more assiduous screening of children referred for early institutionalization.

VII. THE BASIC INGREDIENT: PERSONNEL

The well-rounded program clearly requires a large number of people with a great variety of professional and semiprofessional skills. Some of these needs are well documented (see USOE study on "Competences of Teachers" and

NARO study of "The Need for Professional Personnel in Fields Related to the Education of Mentally Retarded Children"), of others we have the merest guess-timate. For example, the Joint Information Service of the American Psychiatric Association and the National Association on Mental Health reported in "The Staffing of Institutions for Mental Defectives" that there was great variability reflecting little scientific study in the estimates of institutional administrators as to their needs for the various kinds of professional personnel. All reflected a universal sense of inadequacy, however.

Strides are being made in personnel training. However, in 1954 there were only four colleges and universities providing training programs for the new profession of rehabilitation counselor; by 1958 there were 30 such universities enrolling some 500 graduate students in this important field. The American Association on Mental Deficiency and the Council on Social Work Education are jointly working out recommendations for curriculum materials in this field for social students. During this decade for the first time a clinical pastoral training program for chaplains was inaugurated in a State institution for the mentally retarded. A unique program for the preparation of doctoral candidates in psychology with major focus in the field of mental retardation was established, at the George Peabody College for Teachers with a grant from National Institute of Mental Health.

Fortunately both lay and professional people with new ideas and new skills are joining the ranks daily. They are thinking, talking, reading, and writing. (Between 1950 and 1959 the American Journal of Mental Deficiency doubled the number of pages published annually and the new newspaper Children Limited attained a circulation of 45,000.) The retarded, like others, need a place to live, a place to learn, a place to work, a place to play, a place to worship, but most of all they need people. Between 1950 and 1960 more people than ever before learned about, thought about, and did something about the mentally retarded. To sustain this rate of progress is the task of the next decade.

TESTIMONY OF DR. GUNNAR DYEWAD, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION FOR RETARDED CHILDREN, INC.

Mr. Chairman, I greatly appreciate the opportunity to appear before a committee that has done so much to bring about vastly improved opportunities for the mentally retarded in this country. We are deeply indebted to you not only for the legislation which you and your parent committee, under the chairmanship of the Honorable Graham Barden; have so successfully piloted through Congress but also for the helpful effect your warm and sustained interest in the mentally retarded has had on Government agencies, professional workers, and the general public.

I shall desist from reiterating here today facts and figures documenting the magnitude of the problem of mental retardation. You are only too well aware of this. Rather, I want to address myself briefly to some urgent problems in the field of education and rehabilitation which are in the particular purview of your committee. However, I hope you will permit me first to make some preliminary remarks on the urgent need for the development of better, specialized diagnostic facilities.

Unless we have available throughout the country clinics where an adequate early diagnosis can be made of the extent of retardation, and proper recommendations can be made for the management and training of the child, much ground will be lost for the eventual services to be rendered to such child by the public schools, residential facilities, and the rehabilitation agencies.

The mental retardation clinics, established through special appropriations made to the U.S. Children's Bureau, have rendered yeoman service, but all too few communities are blessed with such facilities, and even where there are clinics, long waiting lists exist. Furthermore, even the existence of sufficient diagnostic clinics is not enough, unless we have a means of case finding, some service that will be in a position to locate the parents of retarded infants and direct them to the clinic. Here again the U.S. Children's Bureau has begun to stimulate helpful community action by enlisting the aid of the public health nurse, so often the first of the helping services to reach our families. May we bespeak your interest in this most essential part of a comprehensive mental retardation program.

The need for early diagnosis has been reemphasized most strongly by a recently published study on the value of preschool education and training of the

severely mentally retarded child. I refer to Dr. Samuel Kirk's book, "Early Education of the Mentally Retarded," based on a study made under a grant of the National Institute for Mental Health. Dr. Kirk clearly demonstrates that children who had properly directed preschool training, based on an adequate diagnosis, were in a substantially better position to avail themselves of the programs offered by the public schools or appropriately privately sponsored classes. There is a continuing line from early diagnosis to child health and preschool services, to educational and recreational programs, and other needed community services on to vocational training, sheltered workshops, and job placement. Of course, a large number of the retarded will not reach this ultimate, optimum goal of employment, and, therefore, it is so important to have available, from the outset, good clinical and evaluation facilities to provide for each retarded person the type of program which he is capable of achieving.

May I now address myself to some of our immediate concerns, in the area of special education, as related to your committee's study. First of all, I wish to underline the grave concern of the National Association for Retarded Children, regarding the limited services available from the Section on Services to Exceptional Children and Youth in the U.S. Office of Education. In spite of the devoted and inspired service the staff has given, this Section is ill equipped both in the number of personnel available and in its low position within the echelon of the U.S. Office of Education, to serve the 12½ percent of our school population who, by reason of blindness, deafness, speech defects, mental retardation, emotional and social problems, and other childhood disabilities require specialized education services. Surely, these 5 million schoolchildren are entitled to more adequate attention from their Government. May I emphasize that we are as interested in services to the deaf, blind, or crippled child as in those for the retarded child. What helps all exceptional children helps the mentally retarded, and a lag in service to one of these groups inevitably will affect the others.

Reference to this broad concern of ours brings me specifically to Public Law 85-926, which has become, through the leadership of your committee, such a landmark in the field of special education. We respectfully submit that an extension of this legislation to other areas of exceptionality may well receive priority in the deliberations of your committee. Obviously, the increase, both qualitatively and quantitatively, in advanced postgraduate training in special education will benefit and further strengthen the programs now being set up in colleges and universities specifically for the mentally retarded.

In view of the fact that the significant developments in mental retardation are of most recent origin, it is of crucial import that the Office of Education have available consultant staff to help the various States with planning of these new services to make sure that newly gained knowledge in one State is made available in practical form to the other States and last but not least to provide proper implementation of those public laws which assign to the U.S. Office of Education special program and the program for advanced training in special education.

Strengthening the staff resources of the Section of Services for Exceptional Children and Youth in the U.S. Office of Education is badly needed also on another basis: The more we are thinking of a total program for the mentally retarded the more we must be concerned with close coordination between the education services of primary concern to the U.S. Office of Education and the rehabilitation services of primary concern to the U.S. Office of Vocational Rehabilitation.

Already the public school systems of a few cities have initiated in a number of ways on the secondary level vocational training programs for the mentally retarded. It is of the essence that these programs properly dovetail with the newest developments in the field of vocational rehabilitation. Achievement of this objective, too, will depend on the adequacy of staff resources in the Section for Exceptional Children and Youth.

REHABILITATION

In the area of rehabilitation, I wish to limit my remarks to a consideration of the so-called independent living provisions (title II) in H.R. 3465 introduced by the chairman of this subcommittee, the Honorable Carl Elliott. Suffice it to say that the National Association for Retarded Children strongly supports the other provisions in the bill relating to sheltered workshops, rehabilitation facilities, and competent evaluation services and we are confident that in the future

in all the States every effort will be made to extend these services to all mentally retarded capable of availing themselves of them. However, we are so particularly appreciative of the bill as introduced by Mr. Elliott because it incorporates in a tangible, forward looking way, the knowledge that has only recently been developed: that even with the most severely retarded (and, I hasten to add, the same holds true for other severely handicapped) we can expect definite improvement in their ability of self-care (however limited) if proper, qualified helping service can be provided.

Mr. Chairman, it has been brought out repeatedly in the course of studies in the field of mental retardation, that one of the most serious problems it produces is a drain on the family, necessitated by the extraordinary effort in caring for a severely retarded person. If the provisions of the independent living legislation eventually will make it possible to provide to such families a service so as to make a so-called permanent bed patient ambulant, to help a person to learn how to take care of his bodily needs, to enable a person to lessen his total dependence to the point of making some contribution to family life, the effect can be measured and should be appreciated as definitely as that in the case of a less severely handicapped person who has learned to earn a modest living.

Every day we are learning how seriously we have underestimated the potential in our severely retarded. We are finding increasingly that failure on the part of some retardates has been due to our having placed them too quickly into situations for which they were not yet ready. It is our firm conviction that the independent living facilities foreseen in your legislation will very substantially help the following three groups:

1. Those who are preparing for sheltered workshop and/or vocational rehabilitation services.
2. Those currently homebound but potentially able to participate as active members in the community to some degree.
3. Those currently in institutions who, through such services, as indicated may be returned to their homes.

It has been shown that for every 30 admissions to an institution for the mentally retarded, the State has to be prepared to spend \$1 million during the course of their care. If the independent living facilities and services will make it possible for persons to remain in their own homes who otherwise would have to be institutionalized, a very substantial saving would result. But even for those who now remain in the community, or for those now in institutions, the availability of independent living facilities and services would be of tremendous and lasting advantage.

We, therefore, strongly support, not only H.R. 3465 but in particular want to support title II of this legislation providing for independent living services.

Just as more than 16 years ago in 1943, Public Law 113, popularly known as the Barden-LaFollette amendments, set a landmark for the mentally retarded, so we now want to salute Mr. Barden and Mr. Elliott for their vision in recognizing the potential value of independent living services to the most severely handicapped.

TESTIMONY ON S. 1365, WHICH WOULD PROVIDE FOR THE EXPANSION OF DONABLE PROPERTY AUTHORIZED UNDER THE FEDERAL PROPERTY ADMINISTRATIVE SERVICES ACT OF 1949, SUBMITTED BY THE NATIONAL ASSOCIATION FOR RETARDED CHILDREN, INC., SUBMITTED TO SENATOR ERNEST GRUENING

I wish to thank the chairman and committee on behalf of the National Association for Retarded Children, Inc., for this opportunity to present testimony in behalf of S. 1365.

It has been only due to the imaginative leadership in both Houses of Congress that we have been able to make such outstanding progress in the field of mental retardation.

Tens of thousands of parents throughout the country are grateful. We come to you today confident we can entrust our case to your sound judgment and deep understanding of the problems of mental retardation.

In presenting this testimony it appears best to give you some brief background information on who we are, the group we represent, and then we will describe those of our national activities as manifested by our local units throughout the country which appear to us to fall within the framework of the law (Federal Property Administrative Services Act of 1949) and should be determined to be eligible to qualify to receive surplus property for either health or educational use.

WHO IS NARC?

The National Association for Retarded Children, Inc., known as NARC, is the only national voluntary, parent-inspired association whose primary purpose is to improve the welfare of retarded persons throughout the country. Our member units provide family counseling, special education and training, vocational training, integration to society, and assist in the training of personnel for this purpose.

There are close to 700 affiliated State and local units within the National Association for Retarded Children, Inc. Included in this figure are units in Hawaii, Puerto Rico, and in military installations abroad. The Parents Association for Retarded Children of Alaska, located in Anchorage, has been operating a program for some years and we will imagine one day will be affiliated with the National Association for Retarded Children. Generally, NARC broadens public awareness of problems of mental retardation. Specifically, it provides local units with consultation and guidance to improve their services and gain sufficient support.

There is substantial agreement that about 3 percent of the population, or 5 million children and adults, are mentally retarded to the point of requiring specific services or facilities either throughout their lifetimes or at crucial periods. These services or facilities may involve no more than the provision of special classes in the school system for the upper group of retardates, or permanent nursing or infirmary care for the most severe cases.

In recent years it has been found practicable to divide the total number of retardates into the dependent, the semidependent, and the marginally independent groups.

One person out of every thousand of the total population, or one-tenth of 1 percent, belong in the dependent group, requiring hour-by-hour supervision. As adults they do not go beyond a mental age of 3 years (and many do not go that far). Many of them have severe physical handicaps, are unable to walk or talk; must be fed and clothed. Yet, even in this group some individuals have responded to training along minimum social lines, and these efforts, when successful, decrease the need for personal care and enrich the individual's human existence to the point that he can learn to walk, take care of his bodily needs, and dress and feed himself.

Four persons out of every thousand population fall into the middle group of semidependents. Even the upper brackets of this group develop at less than half the rate of normal children, yet many have capabilities for learning self-care, patterns of acceptable social behavior, and performance of useful work. Where these trainable children are given an opportunity to enroll in well-conducted, well-staffed classes, important advances have been achieved.

About $2\frac{1}{2}$ percent of the population, or 25 out of each thousand people, are found in the marginal independent group. As children they are considered educable, but sufficiently retarded to require attendance at special classes. Most of them can utilize some vocational guidance and training, and many eventually become at least partially self-supporting adults, capable of managing their own affairs, but they will need counseling in periods of stress and crisis.

NARC IN RELATION TO THE ACT

Mental retardation is no respecter of persons. We believe that every child has the right to be understood, respected, and helped regardless of his age, degree of retardation, station of life, economic condition, race or creed. We know that help for the retarded must be provided in a variety of ways. We, therefore, recommend to all of our member units that they provide a comprehensive program for all retarded children.

Some of these services are provided within the framework of agencies, such as the public schools, which serve other children. For others, special facilities may need be created by private resources. All member units affiliated with the NARC have one or several of the following services or functions they provide on a local level.

1. Diagnostic treatment clinics.
2. Home visiting.
3. Nursery classes.
4. Special education.
5. Vocational rehabilitation and sheltered workshops.
6. Community job placement.
7. Protection and guardianship.

8. Community centers.

9. Residence centers.

10. Research.

As we stated earlier for the record, "Many of our local member units find themselves struggling to maintain themselves and few have any sure fiscal or tax base under which they operate." This means that some of our member units provide one form of service or another depending upon their local needs, resources, financial situation, and community support.

We feel that the following information is in keeping with the intent of the act as described under Section 13.2—Basic Policy: "It is the policy of the Department to strengthen and encourage the development and expansion of educational and public health programs and to promote a State of civil defense operational readiness by the equable allocation among the States of donable property for educational, public health, and civil defense purposes, and the assuring thereafter of its maximum utilization for these purposes."

We submit that the information we are presenting in this testimony needs to be properly interpreted so that eligibility to acquire both real and/or Federal surplus property for either health or education by our member units is in keeping with the intent of this act.

We submit that many of our nursery classes, special educational classes, vocational rehabilitation and sheltered workshop programs, community centers, residence centers, and research programs are under the terms of this act potentially eligible to acquire this property.

We have carefully reviewed the Federal Property and Administrative Services Act of 1949 and can honestly say that we are confused by the lack of clarity in both the interpretation and administration of this act as it affects some of these 10 areas of services or functions. What we mean is that in some instances sheltered workshops for example have been approved and declared eligible to receive Federal surplus property whereas in another instance this has been denied. The same holds true for our nursery classes, special education classes, vocational rehabilitation functions, institutions, and research projects.

We will indicate several representative instances where this has occurred and earnestly solicit your assistance in clarifying for us the discrepancies.

EXAMPLE A—WORKSHOPS

An example is a situation in San Francisco, Calif., where we have a vocational rehabilitation center which has twice been "approved" as its instructional standards met those required in the State for such service (vocational rehabilitation) yet has consistently been denied surplus property even though the approving agency is in the Department of Education, of the State of California, in this case the Vocational Rehabilitation Service, which is also cooperating with the Department of Health, Education, and Welfare.

On the one hand this vocational rehabilitation agency which is serving the mentally retarded adult in San Francisco is approved for a Federal grant from the Office of Vocational Rehabilitation under the Department of Health, Education, and Welfare but is denied surplus property by another division within that same Department of Health, Education, and Welfare.

This vocational rehabilitation center provides a preliminary diagnostic workup and receives on those retardates admitted to the program, a medical report, social case study, educational report, and psychological report. It provides both individual and group therapeutic vocational counseling. This program offers vocational training, job placement, and community followup.

This vocational rehabilitation center in San Francisco, Calif., has as its director a Ph. D. and other qualified professional staff members. The other staff members' degrees run from a B.S. to a medical doctor.

They have in addition on their advisory committee some of the top people in the State of California representing medicine, labor, education, and rehabilitation. They meet all of the criteria established under the law as such law refers to eligibility, yet they have been consistently denied the acquisition of Federal surplus property.

Finally this vocational rehabilitation center which is currently receiving a Federal grant which has research as one of its functions and which has been awarded to: "(1) Accelerate vocational rehabilitation services to severely disabled persons; (2) provide for prompt and widespread application of knowledge and experience acquired in the Office of Vocational Rehabilitation research grant program; and (3) test, insofar as possible, the application of the research

findings under varying circumstances in different parts of the country," still is denied Federal surplus property.

In summing up we would like to refer to Title 45—Public Welfare, Subtitle A—Department of Health, Education, and Welfare General Administration, Part 13—Allocation and Utilization of Surplus Personal Property for Educational Public Health and Civil Defense Purposes Amendment. Under "Section 13.1 *Definitions* (c)" "Approved" means recognition and approval by the State department of education, State department of health or other appropriate authority with respect to an educational institution, such approval must relate to academic or instructional standards." Does not this vocational rehabilitation center meet the criteria for "approved" under this act?

We submit that example A just given meets the criteria under "Section 13.1 *Definitions* (n)" "Educational Institutions" means an approved or accredited tax-supported or nonprofit school system, school, college or university." We refer here to the words "approved" and "school," because the candidates for this vocational rehabilitation center all are vocationally evaluated and given their rehabilitation training as a preparation for remunerative employment.

We submit that under the same section (o) "Eligible Applicant" means a civil defense organization as defined in section 13.1(e) or an approved or accredited tax-supported medical institution, hospital, clinic, health center, school, school system, college, university or nonprofit medical institution, hospital, clinic, health center, school, college or university." This example A as cited would meet the criteria and intent of the law particularly as either a health center, school, clinic, or nonprofit clinic.

For the same reasons we submit that example A meets "Section 13.1 *Definitions* (p)" "Health Center" means an approved facility utilized by a health unit for the provision of public health services, including related facilities such as laboratories and clinics."

We submit that example A meets the criteria under "Section 13.1 *Definitions* (x)" "School" means an approved or accredited organization entity devoted primarily to approved academic, vocational, or professional study and instruction which operates primarily for educational purposes on a full-time basis for a minimum school year and employs a full-time staff of qualified instructors."

We submit that the additional material cited below has significant meaning to our testimony as it relates to example A and similar structured agencies being considered eligible to receive said property.

"Title 45, Public Welfare Subtitle A, Department of Health, Education, and Welfare General Administration Part 12—Disposal and Utilization of Surplus Real Property for Educational Purposes and Public Health Purposes:

"Section 12.3 *General policies* (a) It is the policy of the Department to foster and assure maximum utilization of surplus real property for educational and public health purposes, including research.

"(f) Only those activities devoted to academic, vocational, or professional instruction, or organized and operated to promote and protect the public health, are eligible. Examples of such eligible activities are universities, colleges, junior colleges, junior or senior high schools, elementary schools or school systems, vocational or specialized schools, research activities, public libraries, and similar activities primarily educational in character; general and specialty hospitals, mental institutions, clinics, health sanitation activities (including water and sewer departments), facilities providing public health services, and similar activities devoted primarily to the protection and promotion of public health. The program of an institution eligible for a transfer must contemplate use of the property as an integral part of an approved or accredited activity of the kind above described. The activity must obtain such licenses for operations as may be required by State and local law.

"(g) Use of the property applied for must be for a fundamental educational or public health purpose. Examples of such fundamental utilizations are classrooms, vocational shops, libraries, laboratories, auditoriums, gymnasiums, cafeterias, dormitories, faculty housing, infirmaries, recreational facilities, hospitals, clinics, facilities providing public health services, and similar utilization. The property applied for must be for a purpose for which the eligible organization would be authorized to expand its own funds to acquire."

We have taken this time to describe example A, the case of a vocational rehabilitation center, being denied eligible to receive real and/or Federal surplus property because there are currently in operation some 17 such projects across

the country. Four of these projects, to our current knowledge and information, have been declared eligible and are receiving said property. These four are in the States of Delaware, Louisiana, Maryland, and Texas. The balance of the selected research demonstration projects are serving the mentally retarded in the States of Missouri, Washington, Colorado, Rhode Island, Georgia, Illinois, Pennsylvania, Alabama, Tennessee, Ohio, and Virginia. These centers are not to our knowledge receiving said property.

Though we do not have all the information available, but it can be made available, we know that the majority have similar agency structures and have professional qualified staff, advisory committees, and have been approved under their various State vocational rehabilitation agencies as operating recognized rehabilitation training programs.

This is a clear lack of inconsistency, for on the one hand an agency is determined to be eligible to receive said property and on the other hand denied. There is, in our opinion, no substantial difference between the agencies concerned. It points out to us a need for clarification. Needless to say, the tremendous amount of good said acquisition of property could do to further rehabilitate our adult retardates is obvious. In addition, the financial savings to the local, State, and Federal governments would be considerable.

EXAMPLE B—OTHER WORKSHOPS

In January 1959, the National Association for Retarded Children reported on the first nationwide study dealing with sheltered workshops. A summary report prepared by the National Association for Retarded Children discloses that there are 56 sheltered workshops being operated by our member units.

We know that a substantial number of these workshops offer vocational evaluation, personal adjustment training, vocational training, job placement, and followup. A large number of these have been approved by their local and State vocational rehabilitation agencies and are currently receiving training fees for services rendered.

Several of these workshops have previously qualified for and received Federal moneys under Public Law 565, the Vocational Rehabilitation Amendments of 1954. The majority of these workshops have qualified professional staff members operating the program. Several of these workshops have maintained direct referral channels with departments of special education.

It would appear that example B also falls under the category "eligible" to receive said property as either a health or education program.

Those sheltered workshops which do not provide vocational evaluation, personal adjustment training, vocational training, may nonetheless provide supportive counseling, sheltered employment and job placement, and followup. Those aspects of the program other than the sheltered employment it would appear would meet the criteria enabling them to be declared eligible under either health or education.

EXAMPLE C—SURPLUS PROPERTY BROCHURE

The National Association for Retarded Children, Vocational Rehabilitation and Sheltered Workshop Committee during the months of May and June 1958, was in direct contact with the then Acting Chief, Surplus Property Utilization Division, Department of Health, Education, and Welfare and consulted them for advice on the pamphlet titled "How to Acquire Federal Surplus Real and Personal Property" ("Acquiring Surplus Property for Health or Educational Use"), and was told the following: "The material is excellent and contains nothing which is contrary to Federal law or procedure."

The above quote refers to a two-page notice titled "Bi-Monthly Report of Sheltered Workshops and Vocational Rehabilitation Committee, No. 2, August 1958, 'How to Acquire Federal Surplus Real and Personal Property,'" which was sent to all of our member units across the country, our workshop directors and planners, Office of Vocational Rehabilitation, regional representatives, and State vocational rehabilitation directors.

Acting on the information we had from the Acting Chief, Surplus Property Utilization Division, we lead our member units to believe that those member units who operated vocational rehabilitation training facilities might expect to qualify to receive said property if they applied and were declared eligible. It would appear to us that example C further indicates the need for clarification of this act.

EXAMPLE D—STATE INSTITUTIONS

There are in this country more than 100 State institutions for the mentally retarded. Every one of them performs in addition to nursing care for the "crib cases" such services that fall under the headings "Education" and "Health."

Several of our institutions are currently engaged in vocational rehabilitation activities particularly as a means toward releasing those able to function as a contributing member in the community. Institutions in the States of Indiana and Kansas both are operating vocational rehabilitation research projects, in part supported by the Office of Vocational Rehabilitation, Department of Health, Education, and Welfare.

This past year, 10 of our State institutions were visited and their vocational rehabilitation programs discussed with the superintendents and the vocational rehabilitation staff. It is our opinion that every one of these 10 institutions would be most happy to receive said property. Do they not qualify as eligible?

EXAMPLE E—CLINICS

Many of our member units operate clinics for mentally retarded children in cooperation with other local, State, and Federal agencies. Some of these clinics operate under special projects received through maternal and child health funds of the Children's Bureau, Department of Health, Education, and Welfare. Time did not permit us to query all of these clinics but we believe that they would qualify for eligibility to receive said property. Certainly these facilities fall under the category Health.

EXAMPLE F—SCHOOLS

Although we have information to present in behalf of our programs which fall under the act as school, it is our understanding that testimony will be given by a representative from the Department of Education, that is, the U.S. Office of Education, Department of Health, Education, and Welfare.

TABLE I.—*Replies to inquiry "Did you ever receive Federal surplus property?"*

State	Member units reply received	Yes	No	Inter- ested
Alabama.....	1		1	
Alaska.....	1			1
Arkansas.....	1			1
California.....	1		1	
Connecticut.....	5		1	4
Delaware.....	1	1		
District of Columbia.....	1		1	
Florida.....	5		3	2
Georgia.....	5			5
Illinois.....	3			3
Indiana.....	4			4
Iowa.....	4		3	1
Kansas.....	1			1
Kentucky.....	1			1
Louisiana.....	4	1		3
Maryland.....	3	1		2
Massachusetts.....	9	1	1	8
Michigan.....	8			8
Minnesota.....	4			4
Mississippi.....	1			1
Missouri.....	1			1
Nebraska.....	2			2
New Jersey.....	4	1	1	2
New York.....	9		1	8
North Carolina.....	6		1	5
Ohio.....	5		2	3
Oklahoma.....	2			2
Oklahoma.....	9		1	8
Pennsylvania.....	1	1		
South Dakota.....	3			3
Tennessee.....	5	3		2
Texas.....	5	1	1	3
Virginia.....	2	1		1
Vermont.....	5	1		4
West Virginia.....	8		3	5
Wisconsin.....				
Total.....	130	11	21	98

We believe that had we more time in which to gather our information we would have presented additional data to substantiate our testimony. We are sure, Senator Gruening, that you will be pleased to know that we received information from a representative of the State rehabilitation agency in Anchorage, Alaska, who in a personal telephone call to our National Association for Retarded Children said "We have sufficient retarded clients who we are currently unable to serve as well as we would like to due to the lack of suitable facilities which are practically nonexistent. If we could allocate staff to vocational rehabilitation functions for the adult retarded, we would welcome said surplus property."

Senator Gruening, in addition to this information from Alaska we have been receiving telegrams, special delivery letters, airmail letters, telephone calls, and the like from our member units all over the country in response to your directive "that we solicit their assistance in determining whether or not they have ever applied for or received Federal surplus real and/or personal property." We are quite concerned with these replies which will be entered into the record.

We have prepared a digest of the replies we received from our member units. Due to the short notice we received, vacation time of the year, and the lack of all of the messages being delivered promptly, we were unable to receive more replies than we indicate. You will note that our member units in the West and Far West are not included in this report. We did not notify these States because we felt we would not be able to receive replies back in time to meet the deadline date set for this hearing. A reply from California is included because of a recent trip to that State which revealed the information cited in example A.

In reviewing the replies received from our member units when we asked them whether or not they had ever received Federal surplus property, we were struck by several significant factors which appear best summarized below. These replies came from 35 States and represent 130 member units.

1. The majority of those 98 member units who expressed interest in receiving said property stated that they would have applied had they known they were eligible; others expressed a dire need for surplus property to help equip and/or house their classrooms, workshops, day centers, and the like. Still others expressed interest for the future in anticipation of their sponsoring new programs. The receipt of such surplus property would, as we have said before, enable them to initiate programs and render direct services for our retarded children in this country.

2. Those 21 member units who denied the receipt of said property said they were denied eligibility because they did not meet the requirements of the law. (We have already indicated to you under examples A-F our feelings about this.)

3. Of the 11 member units who reported they received said property the donees operate workshops, camp programs, clinics, vocational training programs, special classes, recreational programs.

All of the information contained in this testimony has been presented to the committee in order to show instances where the services and programs provided by the member units of the National Association for Retarded Children properly belong under the current wording of the act, under the categories health and education.

We believe that this is in keeping with the intent of the law, the policy as referred to in this testimony and does not constitute testimony presented as a new agency applying for said property so much as agencies which should properly be recognized as eligible under the current act.

We are deeply interested in those bills which would extend said property so that new services and programs not currently accepted as "eligible" would be included under this act. We are very anxious to have included at this time testimony in behalf of our recreational programs for both retarded children and adults and all other functions which would tend to result in character and individual development of our retarded children and adults.

We, of the National Association for Retarded Children, wish to express our thanks to you, Senator Gruening and your committee, for taking the initiative in holding hearings on those various bills which would provide for the expansion of surplus property. We cannot tell you what the receipt of said property means to every parent of a retarded child when such property enables them to feel there is "help" for them back home in their efforts to provide for their

children as we would for ours. We hope this testimony in part has conveyed that message.

SUPPORTING STATEMENT ON THE REHABILITATION ACT OF 1959 SUBMITTED BY THE NATIONAL ASSOCIATION FOR RETARDED CHILDREN, INC.

The National Association for Retarded Children is pleased to offer its support of the Rehabilitation Act of 1959 on behalf of 5 million retarded children and adults in this country. This testimony will present some background information on who we are, the group we represent, and will describe those of our activities germane to the topic. We will point out how this act would enable vital services which are currently unavailable to be provided for the adult retarded in this country.

WHO IS NARC?

The primary purpose of The National Association for Retarded Children, Inc., is to improve the welfare of retarded persons through counseling for the family; special education and training; vocational training; integration into society; and training personnel. Current research efforts are directed toward prevention.

The National Association for Retarded Children, Inc., known as NARC, is the only national voluntary, parent-inspired association devoted exclusively to an aggressive, united attack on the problems of mental retardation.

There are 658 affiliated local and State units. Included in this figure are units in Hawaii, Puerto Rico, and in military installations abroad. Generally, NARC broadens public awareness of problems of mental retardation. Specifically, it provides local units with consultation and guidance to improve their services and gain sufficient support.

WHOM DO WE REPRESENT?

There is substantial agreement that about 3 percent of the population, or 5 million children and adults, are mentally retarded to the point of requiring specific services or facilities either throughout their lifetimes or at crucial periods. These services or facilities may involve no more than the provision of special classes in the school system for the upper group of retardates, or permanent nursing or infirmary care for the most severe cases.

In recent years it has been found practicable to divide the total number of retardates into the dependent, the semidependent and the marginally independent groups.

One person out of every thousand of the total population, or one-tenth of 1 percent, belongs in the department group, requiring hour-by-hour supervision. As adults they do not go beyond a mental age of 3 years (and many do not go that far). Many of them have severe physical handicaps, are unable to walk or to talk; must be fed and clothed. Yet, even in this group some individuals have responded to training along minimum social lines, and these efforts, when successful, decrease the need for personal care and enrich the individual's human existence to the point that he can learn to walk, take care of his bodily needs and dress and feed himself.

Four persons out of every thousand population fall into the middle group of semidependents. Even the upper brackets of this group develop at less than half the rate of normal children, yet many have capabilities for learning self-care, patterns of acceptable social behavior, and performance of useful work. Where these "trainable" children are given an opportunity to enroll in well-conducted, well-staffed classes, important advances have been achieved.

About 2½ percent of the population, or 25 out of each thousand people, are found in the marginal independent group. As children they are considered educable, but sufficiently retarded to require attendance at special classes. Most of them can utilize some vocational guidance and training, and many eventually become at least partially self-supporting adults, capable of managing their own affairs, but they will need counseling in periods of stress and crisis.

In order to obtain a clear picture of the kind of assistance that has been offered to the mentally retarded person to help prepare him for his contribution to himself, his own family, and to society at large, we need to review briefly two necessary areas in his life development—education and training.

EDUCATION

"The problem of mental retardation has probably existed since the beginning of man. In the United States the first institutions were organized in Massachusetts and New York about 1850. It was believed at that time that the organization of institutions was the solution to the problem. The second development, about 50 years later in 1896, was the establishment of special classes for the educable mentally retarded. Both of these developments have been extended to practically all of the 48 States.¹ Both kinds of organizations—institutions and public school classes for the educable mentally retarded—are still expanding since they have been unable to meet the demands placed upon them.

"Fifty years later, around 1950, we find a third development, the organization of community classes for severely retarded or trainable children, primarily under public school auspices. This third development points up the fact that institutions and public school classes for educable children are not sufficient, and that other provisions are necessary. The efforts of parents to retain their retarded children at home and find community provisions for them has resulted in the organization of classes for trainable children in 18 States.

"But the organization of classes for trainable children in communities is not going to solve the problems of all parents who wish to retain their children at home. There will be many others for which provisions are not available. Who is responsible for the preschool severely retarded child in the home? What provisions will be made for him? Since schools admit only school-age children, will the provisions be day-care centers or classes under a welfare agency? Who is responsible for the severely retarded adult at home? Is the sheltered workshop the answer? And who is responsible for the custodial child if the parents refuse to send him to an institution? Who is responsible for diagnosis and for parent counseling?" (1)

TRAINING

The history of the State-Federal program of vocational rehabilitation in this country dates back to 1920 when the National Civilian Vocational Rehabilitation Act was enacted.

This original act did not provide services for the mentally retarded. With the passage in 1943, of Public Law 113, which became popularly known as the Barden-LaFollette amendments, the mentally retarded were included for the first time among those to be provided with rehabilitation services.

"Prior to 1943, the major emphasis in vocational rehabilitation was on training and placement. Medical aspects of rehabilitation, the psychological impact of the disability, counseling, and interviewing, intensive use of community resources—all those accepted tools of vocational rehabilitation today, were not recognized as basic to vocational rehabilitation until the passage of the Barden-LaFollette Act" (2).

The following services are provided throughout the Nation:

- (1) Thorough physical examination;
- (2) Necessary medical, surgical, psychiatric, and hospital services;
- (3) Necessary prosthetic devices, such as artificial limbs, hearing aids, trusses, and the like;
- (4) Individual counseling and guidance;
- (5) Training for a job in schools, on the job, by correspondence or by tutor or related;
- (6) Maintenance and transportation during rehabilitation, if necessary;
- (7) Necessary tools, equipment, and licenses;
- (8) Placement on the right job;
- (9) Follow-up to make sure the worker and the job are properly matched.

In 1954, "Executive hearings were conducted by the House Committee on Education and Labor and open hearings by the Senate Committee on Labor and Public Welfare. The result was the passage of Public Law 565 of the 83d Congress, which was signed by President Eisenhower on August 3, 1954" (3).

NONPROFIT WORKSHOPS

Under Public Law 565, otherwise known as the Vocational Rehabilitation Amendments of 1954, the vocational rehabilitation program was greatly expanded through a three-part grant structure, making grants available for (1)

¹ This report was written prior to Alaska and Hawaii Statehood.

support of basic State vocational rehabilitation programs; (2) extension and improvement of rehabilitation services; and (3) support of special projects.

This legislation gave impetus to the growth and development of expanded and improved vocational rehabilitation services for the mentally retarded. Sheltered workshops emerged as a new resource in the total effort to rehabilitate the potentially employable mentally retarded.

The National Association for Retarded Children reported in 1959 on a nationwide survey it conducted on 56 member units of the NARC Operating Sheltered Workshops for the Mentally Retarded in 1956-57 (4).

The majority of such programs serve those retardates "who have a reasonable employment potential" through the utilization of the workshop program of service. The three major services rendered by most sheltered workshops include: (1) Vocational evaluation; (2) adjustment and vocational training; (3) remunerative employment.

The last report from the Office of Vocational Rehabilitation (1958) states that 1,600 mental retardates were rehabilitated for gainful employment as contrasted with 1,094 in the previous year.

It has been estimated some 250,000 adult mentally retarded can profit from a sheltered workshop experience" (5). The need for additional facilities of this type are obvious when one compares the number of retardates being rehabilitated annually as of today.

Title III of the Rehabilitation Act of 1959—"Workshop and Rehabilitation Facilities" would provide for additional facilities of this type.

However, our nationwide workshop experiences reveal that the mentally retarded separate out into four groupings within such vocational rehabilitation training programs;

Group description

Group A: Those retardates able to be successfully placed into competitive employment at the end of their sheltered workshop training.

Group B: Those retardates able to maintain productive roles within the sheltered workshops.

Group C: Those retardates unable to maintain consistent productivity within the sheltered workshop.

Group D: Those retardates unable to meet sheltered workshop standards.

Those retardates in Groups C and D require a different type program to meet their needs. Then there are, in addition, a number of severely retarded currently unable to gain admission into sheltered workshops.

INDEPENDENT LIVING CENTERS

In order to serve those retardates in Groups C and D as well as those unable to enter into sheltered workshop programs, additional adult programs are required. These retardates will require such programs in the areas of personal and social development which will enable them to become more self-sufficient and self-reliant.

Title II of the Rehabilitation Act of 1959—"Independent Rehabilitation Services"—would establish a program of rehabilitation, construed in this broader sense. It would enable adult retardates, able to do so, to leave an institution and to achieve such degree of independent living as to dispense with the need for institutional care. It would enable those adult retardates who are homebound to enter into independent living rehabilitation programs thereby largely dispensing with the need for their being attended at home.

If we as a nation are to take advantage of the proposed "independent living" legislation, it becomes imperative that we begin to think now and plan ahead for new facilities and new services for our country's severely retarded adults. Special programs will be required for those unable to become remuneratively employed within the sheltered workshops. New programs will need to place a greater emphasis on an individual's ability to function and to participate within the home, the community, and within an adult activity which need not be vocational in nature. "There is a need to make a life rather than a living" (6).

"For more than 10 years the spotlight in rehabilitation has been on the person with a disability and the team immediately surrounding him. Now the focus should broaden to emphasize the everyday life of the disabled person, his home, community and the society in which he lives, if we are to insure for him a satisfying and productive existence" (7).

As necessary as institutionalization may be for some retardates ("about 150,000 persons were in such public institutions at the end of 1957") (8), there is widespread agreement that those able to remain at home and in the community should be enabled to do so.

Saenger (9) in a comprehensive study of 2,640 severely retarded adults reported that two-thirds "were found to be living in the community. * * * A major part of the study was concerned with the home adjustment of the severely retarded. Most had made a good adjustment; one in four participated in everyday family life, took an active interest in the affairs of other family members, and tried to help within the limitations of their ability. About one-half were able to communicate in a limited way with other family members."

Improved medical care, better dietary management, wholesome activities and work opportunities all seem to contribute to a substantial lengthening of the life span of the retarded. Hence it is of the utmost importance to plan now for the anticipated presence in communities of a substantially larger number of older retardates, through hostels and other residential facilities, vocational opportunities, recreational outlets and appropriate counseling resources.

"I propose that the retarded have the same right as anyone else to be at home and to remain in their communities. This concept implies that, whenever possible, we must minimize the differences between their mode of living and that of others. The greater the likelihood for the retarded to remain with his own family during his childhood, and in his own community as at least a partially contributing member during his adult life, the fuller his life will be. If we agree on this principle, then we must admit that his separation from his family or his community is likely to be a sign of failure, either on his part or on the part of those responsible for his care" (10).

Certainly there is no comparison to the cost involved in providing independent living rehabilitation services to the costs of institutionalization. When one reviews the cost of institutionalization "the average maintenance expenditure per patient (in 1957) was \$1,279.67" (11).

Though there are no accurate figures on the costs of building new institutions, a few costs of recent buildings might be helpful to indicate what part of these costs are:

(1) Arkansas Children's Colony-----	\$1,080,000
(2) Denton, Tex. (being built)-----	2,750,000
(3) State school, Butner, N.C.-----	6,343,000
(4) Selingsgrove, Pa.-----	8,000,000

No one of the above facilities serves more than 1,200 patients.

As Miss Mary Switzer, Director, Office of Vocational Rehabilitation has stated: "For every dollar spent on vocational rehabilitation we can expect a return to society of \$10 in taxes" (12).

Appropriations for the Rehabilitation Act of 1959 are recommended as \$10 million for the first year; \$12,500,000 for the second; and \$15 million for the third.

Why should the National Association for Retarded Children, Inc., discuss institutionalization costs in presenting testimony on a rehabilitation bill? Unfortunately, the group of retardates who would benefit most from the Rehabilitation Act of 1959 (the semidependents, see p. 1 of this report) are, in most cases under current vocational rehabilitation practices (Public Law 565) unable to receive any services whatsoever. Past experience with our adult retarded population clearly shows what occurs when no services are made available in the community. As a result these retardates are either kept at home, left to look out of a window as the world goes by with television (if available) as their major source of enjoyment, (13) or else they are institutionalized.

One of the key provisions of the Rehabilitation Act of 1950 is "Title IV: Rehabilitation Evaluation Services." "The term 'rehabilitation evaluation services' means (1) diagnostic and related services (including transportation) incidental to the determination of the nature and extent of an individual's physical and mental impairment and rehabilitation potentials and the rehabilitation services required to realize these potentials, (2) the determination of appropriate referral of such individual for vocational rehabilitation services as defined in title I of this act, independent living services as defined in title II of this act, or other needed services provided by public or private agencies (4).

Under the present laws, State rehabilitation agencies could conceivably provide this service to applicants for vocational rehabilitation, but have shown them-

selves reluctant to do so when the prognosis appears to be something less than vocational rehabilitation.

Many people believe that the weakest element in present vocational rehabilitation programs is that of evaluation. The National Association for Retarded Children feels that the need for effective evaluation services would be intensified, if the States accepted responsibility for the rehabilitation of persons who would not be required to have vocational potential at the time of application. If this title becomes effective, it is believed that it will accomplish more than any other one thing could do to systematize and bring order into rehabilitation activities, assuring that no one is denied at least an adequate evaluation. It would furthermore, centralize in one place, under one agency, evaluation services for all adults.

Vocational rehabilitation services should be greatly improved, particularly for the severely retarded. It should no longer be required that the agency decide in the beginning whether the handicapped individual can be vocationally rehabilitated. This will result in the acceptance for services of many retardates who otherwise would have been rejected, without being given an opportunity to actually demonstrate their potentials.

It is logical to assume that there will be a number of retardates who will be able to progress from an institutional or home setting to a life in the community. These retardates may even make a partial contribution and some will make a full contribution to their families, themselves, and to society through either sheltered employment or full-time employment.

Whether we call the mentally retarded, subnormal or deficient; whether their disability is mild, moderate, or severe; whether they are capable of being dependent, semidependent, or semiindependent; extremely retarded, trainable, or educable, unless we provide for their needs, account for their individual differences, and recognize that they, like all of us, function on different levels at home and in our society at large; then we will further retard their development and deny them the opportunity to make a contribution, not only to their families, to the total social effort but to themselves as individuals. And it is this right, once provided, that will again affirm what is essential and unique in our American way of life.

In speaking about the physically handicapped in the publication, "The Handicapped and Their Rehabilitation" Hoerner says: "Through a functional activities treatment program, it has been demonstrated the the individual's physical and mental reserve potential (his safety factor) capabilities can be brought forth, and that eventual adjustment of total or partial physical and vocational independence can be achieved. Functional training directed toward four major objectives have been grouped under the term "activities of daily living":

- (1) Maximum use of the hands in all self-care.
- (2) Ability to travel about.
- (3) Adequate speech.
- (4) Normal, near normal, or good cosmetic appearance" (15).

This above quotation describes training objectives in rehabilitation which excludes the mentally retarded. Are the retarded without the need to learn how to use their hands effectively, productively? Do they not need to travel about? Are they not able to use speech? Should they not be as normal looking as possible?

The counterpart program for the mentally retarded which would provide for activities of daily living is called personal adjustment training. A working definition of personal adjustment training might well be "personal adjustment training is the process of providing social, emotional, personal, spiritual, and physical experiences for the mentally retarded as a necessary step toward their living independently in society."

The program, physical demands of daily life as developed by the Institute for Crippled and Disabled in New York (16) could be adapted so that the needs of the mentally retarded were properly recognized. It could become an integral part of the personal adjustment training program with one major difference. Instead of providing instruction and training toward employment preparation, the initial emphasis would be instead on both home adjustment and community participation.

By providing for developmental experiences in the area of fundamental home skills (meal preparation, dishwashing, care of clothes, bedmaking, room care, local travel, and other self-care activities) a foundation is laid for family relationships, home responsibilities, and independent living.

Additional graded experiences and opportunities for everyday social activities, proper use of leisure time, avocational skill development, interpersonal

relationships, and personal need fulfillment pave the way for good health habits, individual adjustment, and community participation.

In some instances, as a byproduct of these independent living rehabilitation activities those retardates able to progress and partake of sheltered workshop programs will be better prepared for such vocational training programs. Because of their participation and sharing in home responsibilities and community activities, they will be more wholesome well-rounded individuals. Their personality development will be reflected by the gains they make through successful personal, social, and interpersonal relationships.

In all instances, the severely retarded will be able to live a more fruitful, less dependent life thereby becoming less of a burden to themselves, their families, and society. Such an undertaking of this type is in keeping with our democratic way of life and is in the public interest.

The Rehabilitation Act of 1959 will enable a considerable number of the mentally retarded to become rehabilitated. Too often the end of education for our severely retardates has resulted in a return to their homes or institutionalization. Our hopes lie in this act which will provide so much help to those who need others so that they can help themselves.

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(4) "A Summary of Sheltered Workshop Questionnaire," NARC, January 1959.

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(7) Leonard Mayo, "A Summary Report of Round Tables, the Place of Persons With Disabilities in Our Society," Association for the Aid of Crippled Children, 1957.

(8) Mental Health Statistics, U.S. Department Health, Education, and Welfare, Public Health Service, National Institute of Mental Health, August 1958.

(9) Gerhart Saenger, "The Adjustment of Severely Retarded Adults in the Community," New York, 1957.

(10) George Tarjan, "The Mentally Retarded Are Part of Our Community," University of Minnesota, January 1959 (paper).

(11) Mental Health Statistics.

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(13) "Retarded Children Can Be Helped," Cornell Capa and Maya Pines.

(14) Rehabilitation Act of 1959.

(15) "The Handicapped and Their Rehabilitation."

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Mr. ELLIOTT. I have spoken to Dr. Foureacre a while ago about giving us a statement with respect to the use of the fellowship provisions of this Public Law 85-926 in his institution, but I believe he has gone.

Our next witness is Dr. George H. Schroeder, of the Bronx Society for Prevention of Cruelty to Children.

STATEMENT OF GEORGE SCHROEDER, PRESIDENT, BRONX SOCIETY FOR PREVENTION OF CRUELTY TO CHILDREN

Mr. SCHROEDER. Mr. Chairman and members of the committee, I am president of the Bronx Society for the Prevention of Cruelty to Children, located at 609 East 163d Street, Bronx, N.Y.

Ours is the only children's society serving a community of 1,500,000 persons.

I have been affiliated with the organization for years, the last 10 of which I have served as its president.

Our society was created as a consequence of an urgent appeal made by the New York Society for the Prevention of Cruelty to Children, which found that due to limitation of resources it was unable to properly serve the phenomenal increase in referrals brought about by an increase of population.

Hence the public-spirited men and women of the Bronx established their own organization.

The articles of incorporation for the Bronx Society for the Prevention of Cruelty to Children states the particular object for which the corporation is to be formed is the prevention of cruelty to children.

The extension of these objectives would include neglect of children, abuse, exploitation, and cruel treatment; also abandonment, failure to provide, endangering the life and health of children, as well as supervision in the areas relative to the employment of minors in hazardous occupations; the attendance of children at prescribed resorts, such as poolrooms, dancehalls, and places where liquor is sold, as well as the city code of ordinances which requires that society process all applications for the applicable performances by children.

Mr. ELLIOTT. Does your society recommend against parents spanking their children, Mr. Schroeder?

Mr. SCHROEDER. Do they recommend against parents spanking their children?

Mr. ELLIOTT. Yes.

Mr. SCHROEDER. We haven't taken a stand as to whether they should be spanked or not. I have personal feelings on that, but there are times when they are overspanked and times when they should be spanked.

I believe the rod should be used at certain times, but to a degree of commonsense.

The increased costs of operation, as well as an exploding population growth, does not permit us to fully serve the child welfare needs of our community, due to very limited resources.

Our situation is further aggravated by a marked change in population characteristics. The greatest population changes in the Bronx have occurred with respect to the growth of population in two ethnic groups.

Informed statements made by the city planning department indicate that the number of Puerto Ricans, for instance, of the first and second generation living in the Bronx, is in the vicinity of 140,000 to 150,000.

The growth of the Negro population in the Bronx, while it has been steady, occurred for the most part in the years between 1940 and 1950.

In 1920 only 4,803 lived in the Bronx. The number has grown to 12,930 by 1930 and 25,529 by 1940.

During the 1940's, however, over 74,000 were added—an increase of 315 percent.

A substantial proportion of the New York City public assistance caseload is drawn from these underprivileged groups. This is not surprising when one considers that these groups are heavily concentrated in the more unskilled, low-paid occupations, suffering as they do from lack of education, the difficulties of adjustments to their new environment, and from a degree of discrimination.

We believe our major problems with the children and adults to be classified as problems of the socially handicapped and the emotionally disturbed. Therefore, we feel that they should be the concern of this committee on special education as one of the major problems of our community and other similar communities throughout the Nation.

We believe these problems in the great metropolitan community such as ours cannot be solved by the local community alone. We are ready and willing to bear our share of the burden, but the tremendous influx of people from all States of the Union to the New York area and the Bronx has placed the burden upon local agencies far beyond their power to carry alone.

We feel that some form of direct aid from the Federal Government to the public and private agencies of this State trying to meet this urgent need of our antiquated service program for these visually and emotionally handicapped children should be coming forth soon.

We stress direct aid because we believe we exist to give immediate services to needy children and adults requiring treatment.

We do not depreciate the value of research, but we have a problem in supplying direct services, social work, psychiatric services, parent education, and immediate protection to the children of our community, which is of sufficient magnitude to cause us concern for our day-to-day problems.

With some outside supplementary aid, we believe we can service our city in a practical and concrete way.

The form of this Federal aid must, of course, be left to your committee, but without some direct aid hundreds of children and families will continue to go unaided.

We believe our city and State can do more, and we as community leaders can make a determined effort to close the gap between needs unmet and facilities to meet them.

But we cannot do it alone.

I appreciate very much this opportunity to speak before you. Thank you.

Mr. ELLIOTT. Thank you very much, Mr. Schroeder. We are happy to have heard you.

If you have any further evidence, or if you did not read all of your statement, we will be happy to have it within 10 days to include in the record.

Mr. SCHROEDER. Thank you.

Mr. ELLIOTT. Now, as our hearings come to a close, may I, on behalf of the Subcommittee on Special Education, take this occasion to very sincerely thank Dr. Merle Frampton, who heads our special education and rehabilitation study.

Thank you very much, Dr. Frampton, on behalf of the committee.

Now, may I thank the members of the subcommittee who have been so kind as to work long hours these past 2 days.

At the same time, I would like to thank the employees of the subcommittee for the very fine and efficient service that they have rendered.

The subcommittee will probably meet around the middle of December for hearings in New England area.

The members of the subcommittee will be advised just the very minute that I can determine first whether or not the hearings can be had, and, if so, where and when.

At this point in the record I will place a copy of a statement from the New York Service for Orthopedically Handicapped, dated October 29, 1959.

(The statement referred to follows:)

STATEMENT OF DR. MELVIN HERMAN, EXECUTIVE DIRECTOR, NEW YORK SERVICE
FOR ORTHOPEDICALLY HANDICAPPED

Mr. Chairman and members of the committee, I am Melvin Herman, executive director of the New York Service for Orthopedically Handicapped, a voluntary agency which has long been concerned with services to the disabled. In the 54 years of our agency's existence, we have offered a variety of services to handicapped children and adults, including special schooling, shelter employment, summer camping, and year-round recreation. We have just begun a modest new program of independent living which will attempt to provide foster homes or apartments for handicapped young adults who are currently living in hospitals or in the community under unsatisfactory circumstances.

In the course of offering our other services we have seen numerous situations in which handicapped persons, having achieved maximum medical rehabilitation, continue to live in hospitals or other institutions because no other suitable alternatives exist. We are deeply convinced that a new approach is needed and it is for this reason that our agency most strongly supports the intent of H.R. 3465.

I would like to recommend that your committee expand the proposed definition of the term "independent living rehabilitation services" to include recreational programs. It is apparent that one of the serious consequences of long-term disability, particularly those occurring at birth or in early childhood, is the lack of group experiences, which in turn often produce later difficulty in adjustment to work situations involving sharing with others in the accomplishment of a common task. We believe that for many individuals such group experiences can be extremely useful in assisting handicapped adults toward independent living by better preparing them for maximum participation in community life. It is an unhappy fact that few, if any, existing agencies such as community centers and Y's permit or encourage participation in their programs by handicapped adults. I would hope, therefore, that appropriate ways be found to include recreational services within the term "independent living rehabilitation services." I believe that the availability of funds would permit us to open the doors of existing recreational programs and, if needed, create additional services for this group with special needs.

I would also urge some clarification of section 206(b) as it pertains to "attendance in his household." I would hope that the intent of this provision is not to exclude those who may well achieve a degree of independence but who may require the somewhat protected environment of a foster home for a continued period of time. I further hope that persons would not be excluded who might live in independent apartments, perhaps with another handicapped person, where they might require some part-time and continued help for the purposes of cleaning or assistance in meal preparation.

We believe that foster-home care, which has been so dramatically demonstrated in the field of the aged and the mentally ill, can substantially contribute toward the reduction of our hospitalized population and at the same time reduce the numbers of handicapped adults currently at home who will be institutionalized after the death of one or both parents. Unfortunately, under current policy, in New York City at least, the amount authorized through public assistance effectively precludes the possibility of finding suitable foster homes by establishing a maximum payment of \$100 per month. Many of my colleagues and I believe that if this rate were to be increased to \$160 or \$175

per month a number of handicapped persons would be able to leave hospitals where tax funds are now supplying between \$600 and \$700 per month. Perhaps the bill under consideration could be used to stimulate the development of such a program, which undoubtedly could produce a greater degree of independent living at a reduced cost to the taxpayer.

Thank you very much for this opportunity to present our point of view. We are convinced that H.R. 3465 represents a most significant step forward in the field of rehabilitation from both a humanitarian and business point of view.

(The following letter and statements were submitted:)

HOUSE OF REPRESENTATIVES,
Washington, D.C., November 9, 1959.

Hon. CARL ELLIOTT,
Chairman, Subcommittee on Special Education, Committee on Education and Labor, House Office Building, Washington, D.C.

DEAR CONGRESSMAN ELLIOTT: I greatly regret that I was unable to be present at the hearings of your subcommittee in New York, October 28 and 29. Unfortunately, as you know, we had local elections coming up about that time and my calendar was very full.

However, I have great interest in the study of your subcommittee. The problem of rehabilitation and care of the handicapped is one meriting serious study. There are at present pressing needs in this field. A review and analysis of the inadequacy of present service to ascertain duplication and to determine future needs is, I am certain, a constructive first step. There appears room for reorganization, and perhaps new services. I know that New York has taken a lead in such programs and I support Governor Rockefeller's studies in this field.

I would be appreciative if this letter showing my concern for the problems and my sympathy with your studies should be inserted in the record of the New York hearings.

Sincerely yours,

BOB BARRY.

RECOMMENDATIONS OF THE CITIZENS' COMMITTEE FOR CHILDREN OF NEW YORK, INC.

The board of directors of the Citizens' Committee for Children of New York welcomes your invitation to submit recommendations concerning special education and rehabilitation of physically and mentally handicapped children and your request for comments on the bills now before your committee.

Many organizations concerned with specific aspects of this complex subject will be testifying on matters within their particular fields of interest and competence, such as teacher training, curriculum, school plant and equipment, or on the problems peculiar to patients suffering from the major disabling diseases. They are the immediate concern of national and local organizations devoted to their alleviation and eventual elimination.

We are not a specialized organization but are concerned with the improvement and effective coordination of all children's services. The Citizens' Committee for Children combines within its membership the professional knowledge and skills of experts in all phases of health, education, and welfare services to children and the interested participation of our informed, experienced lay members. Through its working sections—health, mental health, education, child-care, and protective services—it pools not only the knowledge and experience of its own membership but the benefits of consultation with an equally broad range of technical advisers, civic groups, and heads of operating agencies in all related fields. Our contribution to any consideration of specific needs and resources for the health, education, and welfare of children lies in this pooling of interdisciplinary professional experience and the thoughtful participation of civic leaders who must, in the long run, be responsible for interpretation and support of community programs.

CITIZENS' COMMITTEE ACTIVITIES IN THIS FIELD

It is in this context that we have undertaken projects in such related areas as school services for physically handicapped children, a community program for the mentally retarded, a mental health program for children, a pattern of

services for children in trouble.¹ In each instance we visit the institutions and agencies involved and gather, evaluate, and report on pertinent data. We bring together those who are interested in and, in many instances, responsible for the quality and quantity of such services. The aim is to help crystallize from the various and often differing points of view a program that is geared to the growing child and his family in his home, neighborhood, and community.

BASIC PRINCIPLES

We should like to offer for your consideration certain basic principles which have guided us in our work for improved children's services and which may be of use to your committee as you review the numerous specialized proposals that will come your way.

We recognize the great need for more and better services of all kinds but believe proliferation of services is in itself not the answer. Our basic concern is the child who is the recipient of community services. Unless services are adapted to the needs of the individual child and coordinated for his benefit, they will fail to serve his best interests. Similarly, while diagnosis without service is often an empty gesture, service without adequate diagnostic evaluation is not only unwise but often potentially harmful. Furthermore, special education for children with special needs cannot be provided effectively in school systems that do not provide adequately for the education of all the children in the community; nor can the handicapped child derive maximum benefit from special education that is not an integral part of the total community effort to help him and his family.

The underlying theme in all of this is community accountability, the assumption of responsibility for seeing to it that once a child is found to need help he is not lost amid the plethora of specialized, fragmented services that abound in most communities. For the handicapped, this begins with comprehensive diagnostic evaluation and planning in cooperation with the child's parents and includes regular medical supervision, periodic reevaluation and modification of program—in school and out—as the child grows and his needs change.

COMMENT ON H.R. 3465

We therefore find ourselves in full agreement with the intent of H.R. 3465, which provides for the "evaluation of rehabilitation potentials and rehabilitation services to severely handicapped individuals," particularly section 302B providing for "an integrated program of medical, psychological, social, and vocational evaluation and services under competent professional supervision," and section 203(a) (7) which stresses "cooperation by the [responsible] State agency with and the utilization of services of all" the appropriate Federal, State, and local agencies providing related services.

We might also point out that while rehabilitation services for those over 16 are obviously necessary, the earliest possible identification of the handicapped child, followed by diagnostic study, treatment, and appropriate educational, social, and vocational preparation are equally, if not more, important in the total lifespan of the individual. Vocational rehabilitation of the older adolescent and adult is thus dependent on the basic community health, education, and welfare services and the use which is made of them for the younger handicapped child, beginning as soon as a diagnosis can be made and continuing—with focus on the child—throughout his growing years.

While we applaud the inclusion of the mentally as well as the physically handicapped in H.R. 3465, we suggest that it might be well to define the term "mentally handicapped" more precisely. Too often in legislation and program planning, "mentally handicapped" is equated with "mental defect or retardation." This bill seems to us to include the mentally ill and emotionally handicapped as well as retarded, but may not be so interpreted unless it is clearly stipulated.

We should also like to call your attention to a growing group of young people for whom this bill might represent a veritable godsend but who are not mentioned specifically. These are the boys and girls of 16 and over who are coming out, or

¹ Attached are two memorandums: "A Community Program for the Mentally Retarded," November 1955, and "Recommendations of Ad Hoc Group on School Services for Physically Handicapped Children in New York City," Mar. 26, 1956. While both are to some extent out of date and limited to the specific purpose for which they were prepared, we hope you will find them pertinent and useful, particularly since in the intervening years several of the major recommendations have been accepted and implemented.

rather, could come out of institutions, both public and private, if there were available the kinds of services outlined in the bill. For example, in addition to the children in State hospitals and State schools for the mentally retarded, there are many in institutions for the delinquent or neglected and in residential treatment centers for emotionally disturbed children who are mentally, emotionally, and socially disabled within the meaning of this bill who could, with the services herein provided, be helped to make a more adequate adjustment in the community and cease to be a burden on such families or portions thereof as they may have or on society at large.

We hope, too, that in the implementation of this bill the significant psychological and social components in the rehabilitation of the physically disabled will be stressed, so that States and local communities planning facilities for the physically handicapped will not only be encouraged but assisted in the provision of psychological evaluation, counseling, and social services to the physically handicapped. Similarly, we urge that rehabilitation programs, including workshops for the mentally ill and retarded not be confined to one or the other category or to the "mentally" or opposed to the "physically" handicapped. Recent experiments have demonstrated that arbitrary separation of the physically and mentally handicapped is not only unnecessary but often unwise, except as required by individual patients on the basis of thorough diagnostic evaluation.

COMMENT OF JOINT RESOLUTIONS 316 AND 494

Joint Resolutions 316 and 494, which are concerned with the training of teachers, speech pathologists, and audiologists for work with persons suffering from hearing and speech defects, are also worded in a manner which seems to us to give due consideration to the medical, social, emotional, and other aspects of rehabilitation, in addition to the educational aspects. We know of the shortage of trained workers—teachers and other specialists—not only for this group but for all other handicapped children; our members are involved in the training, recruitment, and supervision of all categories of personnel in this field. On this occasion, however, we would stress the social and emotional component, not only in the selection of those who are to work with these children but also in the selection of the children to be served.

Children with speech and hearing defects present a special diagnostic problem, as all who have worked with them must know. Hearing deficits vary within the individual child according to time, place, and circumstances; such variations are even more marked in those with speech defects. Differential diagnosis of the most careful sort is essential to the accurate identification of these children, and to their class assignment and program. The interplay of psychological and organic factors cannot be overemphasized and the teacher who would work with them must be helped to understand this.

ROLE OF THE FEDERAL GOVERNMENT

Bills of the kind proposed here have the added advantage of providing the Federal Government with the tools it must have if it is to help the States and, through them, the individual children in the local communities. They provide for grants-in-aid and, what is just as important, technical assistance. This cannot be stressed too strongly. Our national experience with the implementation of the 1946 extension of the Vocational Rehabilitation Act to include the mentally as well as the physically handicapped points up the pitfalls and shows us how to avoid them. Of prime importance in avoiding the timelag in implementation and the failure to interpret the Federal act as broadly as it was intended when written and passed, is the technical assistance to be provided by the Department of Health, Education, and Welfare.

This will require skilled staff in all the appropriate agencies of the Department as well as effective coordinating machinery at the Federal level to bring to bear on the individual to be served, the specialized knowledge, experience, and facilities of the entire Department. We have long stressed this at both State and local levels. As you may know, New York State now has an official coordinating mechanism for the kinds of services with which your committee is concerned. More remains to be done but at least the necessity for it has been recognized by statute.

Finally, may we thank you for making time available and express our regret that a prior commitment made it impossible for our representative to testify at the New York City hearings at the scheduled time. Documentation of the prin-

ciples outlined in this statement will, of course, be available to your committee on request and we will be happy to be called upon at your convenience for further discussion of implementation.

RECOMMENDATIONS OF AD HOC GROUP ON SCHOOL SERVICES FOR PHYSICALLY HANDICAPPED CHILDREN IN NEW YORK CITY

The New York City Board of Education and the Department of Health of the City of New York now operate programs which permit many physically handicapped children to attend school. There are 6,000 physically handicapped children under the supervision of the board of education. The handicaps include orthopedic, neuromuscular, neurological, cardiac, hearing, sight. However, many children (1,700 in New York City) are now homebound either because their handicaps are too severe for education in a regular school or because adequate services and transportation do not exist to bring them to the public schools. Studies have shown that many of these homebound children could profitably attend school. It is therefore recommended that the board of education and the department of health provide the necessary additional services and facilities for this group of children. Measures to strengthen services to all handicapped children at home or in special or regular classes should be implemented. At the same time an attempt must be made to keep all of the physically handicapped children as much as possible in the mainstream with other children.

Severely physically handicapped children require careful medical supervision and special physical facilities. In addition, special psychiatric factors must be considered. The goal in education of these children is to fill the child's needs. These needs are more difficult to meet than those of normal children. The school must deal with the problems which stem from the family where feelings of anxiety, fear, and guilt sometimes result in overprotection or other mishandling of the child.

In addition, there is frequently lack of acceptance by other children in the community. The school must help the handicapped child to build up a realistic concept of himself through exposure to a variety of experiences. The handicapped child needs the support of his environment longer than the normal child and the parent and teacher must be helped to see when and where to withdraw their particular support.

Though the goal is to transfer as many of these children as possible into the "mainstream" as soon as possible, segregated programs are necessary until the children are ready to go into regular programs.

Some of the recommendations which follow were included in the report of the commission for the study of crippled children in 1940 ("The Crippled Child in New York City").

With the increase in the child population and a proportionate increase in the number of handicapped children, as well as increased knowledge of how best to rehabilitate the handicapped, it is even more urgent now to provide the necessary services.

I. IMPROVING QUALITY OF SERVICE IN EXISTING PROGRAMS

(A) School buildings: Additional space should be provided in existing buildings or buildings under construction to handle the children who should be served in the schools. (See II(A).)

(B) Planning for handicapped children to be effective must be comprehensive rather than segmented and should include all aspects—educational, psychological, medical and social. Individual planning must be done for each child.

(C) Health conservation classes: Since the vast majority of severely physically handicapped children are now in health conservation classes, steps must be taken to review the setup, program, and children in these classes. The services found necessary as a result of such review should be provided.

(D) More definitive and uniform criteria for admission and discharges of children to both the cerebral palsy units and the health conservation classes should be spelled out. No hard and fast criteria are possible since many factors including the emotional state of the child must be considered in the decision regarding placement.

(1) Whenever it is deemed necessary (within staff limitations), there should be a team review of children before admission, and "paper review" of children should be eliminated.

(2) The possible extended use of facilities in the community, primarily hospitals, for such study should be investigated.

(E) A flexible system should be worked out and instituted whereby physically handicapped children are easily transferred from one setting to another depending on their needs and abilities at any given time; for example, from institution or homebound to special classes or eventually to regular classes. (See II(D) (2).)

(F) Census of needs: Some steps have been taken to "review" the children who are now homebound or in special classes. However, it is suggested that—

(1) all children who are now homebound should be screened periodically on a pilot basis as soon as possible to determine how many could go to school if there were special facilities for them and what those services would have to be;

(2) all children now in special classes for the physically handicapped should be reviewed periodically by a team to determine how many could be in regular classes;

(3) some attempt should be made to locate and review the children getting no service (children excluded from school and not on home instruction).

(G) Personnel: (1) Present teacher training and selection methods for those who will deal with handicapped children should be reviewed in view of the changing philosophy regarding the educational, social, psychological, and physical needs of the handicapped. In the light of changing concepts, the present staff assigned to handicapped classes should be reviewed. The problem of what constitutes a minimal training program for teachers of the handicapped should be explored (with the suggestion that practical experience should be an element in such training).

(2) Through the city colleges and other teacher-training institutions and inservice training courses, teachers and supervisors should be helped to gain greater understanding of the handicapped who will, we hope, in increasing numbers be students in their classes along with the normal children. All school personnel should be properly oriented to the philosophy of the school toward the handicapped child.

The board of education gives inservice training to teachers of the physically handicapped and has issued a manual on the education of the physically limited child. However, much remains to be done with the regular teachers and supervisors in the schools.

(3) Extra incentives are needed to attract qualified and dedicated personnel to work with the handicapped since this work involves greater responsibility, more tiring work, and longer hours than work in other settings.

(H) Psychological and psychiatric services: (1) Intensive counseling and vocational and other forms of guidance should be available for physically handicapped children as it is needed. As techniques are developed for proper vocational guidance for the younger age group, these should be available to the physically handicapped children.

(a) Counseling should be available to parents as well as children.

(b) The possibilities of using other public or private agencies in counseling should be explored.

(2) More psychiatric guidance services must be provided to deal with the many problems which arise in a program for physically handicapped children. A psychiatrist should be available for consultation with "the team" which screens and services physically handicapped children. The possibility of making wider use of clinical facilities in hospitals should be studied.

II. NEEDED EXPANSION OF SERVICES

The present practice is to limit enrollment in special classes for severely orthopedically handicapped children to those with cerebral palsy; all other children with severe orthopedic handicaps are now excluded:

Wheelchair cases are not permitted in any classes except those for cerebral palsy.

Children in other classes for the handicapped, called health conservation classes, must be able to get on and off the bus without assistance, while limousines bring the cerebral palsy children to school.

With a view toward providing education in the schools for some of the other children who are now homebound, the following recommendations are made:

(A) School buildings: Plans for new schools or remodeling existing schools should include:

(1) Units on the ground floor in a few schools in each borough for the physically handicapped; special facilities, including rails, ramps instead of steps at the entrance, bathrooms with rails and wide doors.

(2) Most schools should have one or more classrooms built on the ground floor with wide doorways so that if they are needed for the physically handicapped, they are available; if not, they can be used for regular classes.

(B) Expanded program for severely physically handicapped: A pilot project in which present cerebral palsy school units would be expanded to screen and care for a group of severely handicapped children with other disabilities should be started. Such a pilot project would show the needs of other handicapped children, some of whom are now homebound or in institutions. Additional staff (medical, social workers, psychologists, teachers, therapists, etc.) will be required to screen and care for these children in this expanded program. The same team screening methods and the same techniques of team approach can be used in these enlarged units. If this pilot project shows that these other groups of severely handicapped children can take part in a school program, special units should be set up in each borough with all of the necessary facilities and trained staff to care for them.

(C) High school classes: The special facilities for severely handicapped children should be extended through high school since many orthopedically handicapped children must now become homebound when they reach high school age. Some special services do exist for the blind, partially sighted and deaf, and some cardiac children do attend high school.

III. TRANSPORTATION

Available transportation facilities will, in part, determine which children can go to school. In addition, some of the children spend hours in the school bus. Therefore, it is important to improve transportation services for the physically handicapped in many ways, following the recommendations in the welfare and health council study on transportation of handicapped children.

(Memorandum to Senator Earl W. Brydges, chairman, Joint Legislative Committee on Mental Retardation, from the Citizens' Committee for Children of New York City, Inc.)

SUBJECT: A COMMUNITY PROGRAM FOR THE MENTALLY RETARDED

BACKGROUND

The Citizens' Committee for Children of New York City is an organization of lay and professional persons who are deeply interested in the quality and quantity of services for children in New York City and who bring to the work of this organization a wide range of expert knowledge and experience in all phases of health, education, and welfare. The Citizens' Committee has worked long and hard for the improvement of our community services, and in each instance has based its efforts on factfinding, research, expert consultation, and constructive working relationships with the appropriate public and voluntary organizations and professional groups.

In the course of our efforts to stimulate public interest in meeting the unmet needs of all the children, we have consistently given particular attention to those children who have special needs. We believe that the mentally retarded have very special needs which have not been met. For some time the Citizens' Committee has been deeply concerned with the tragic problems faced by the mentally retarded and their parents, and, more recently, a subcommittee of experts in health, education, and mental health has been working intensively on the subject. The subcommittee has reviewed the literature, visited service programs, and conferred with National, State, and local specialists in the field.

As you know, the Citizens' Committee has in the past recommended certain long-range programs for this group of children and has suggested various approaches to their achievement. We have prepared annual statements for consideration by the legislature and were pleased to find that several of the specific recommendations contained in these statements have been implemented. However, they represent only first steps in a long journey, and much more needs to be done.

The Citizens' Committee was particularly pleased to learn of the appointment of this joint legislative committee on mental retardation under your leadership because it is such a clear indication of a growing recognition of the importance, severity, and complexity of the problem. Your long interest in finding solutions for these problems is our assurance that the joint legislative committee may well be the catalytic agent which has so long been lacking in this field.

SCOPE OF THIS MEMORANDUM

Our subcommittee on program for the mentally retarded is working intensively on specific recommendations for the implementation of the comprehensive community program for the mentally retarded which was outlined in our earlier statements. The subcommittee has not yet completed its final report to the board of directors of the Citizens' Committee for approval and subsequent release. We shall, of course, be happy to make it available to the joint legislative committee immediately thereafter.

In the meantime, however, the Citizens' Committee for Children is in a position to point out and define certain areas of major priority and fundamental importance to any program that is now contemplated or may eventually be adopted. The nature of these priorities is clearly indicated by the following three major problems which must be faced and resolved if services for the mentally retarded are to move forward in an organized, coordinated program:

I. There is today no formal recognized coordination between or among Federal, State, and local public agencies or between public and voluntary programs in this field; this has resulted in confusion, duplication, and overlapping services on the one hand and great unfilled gaps in service on the other.

II. There is today no clear allocation of public responsibility in the local community for early case finding, comprehensive diagnosis, or parent counseling, or for the establishment and coordination of the wide range of services that are known to be needed by the mentally retarded and their families.

III. There is today no organized program for public and professional education about mental retardation and about the needs of persons found to be mentally retarded. Nor is there an organized program of recruitment and training of professional personnel who are so desperately needed in this field. There is a similar lack of organized, coordinated research.

ELABORATION

I. Coordination of public and voluntary programs.—The mentally retarded and their families have in the past been served by a number of different public and voluntary agencies, but seldom in a coordinated fashion and for the most part inadequately. Since the needs of the mentally retarded—as of all children and adults—cut across formal agency lines and since, in the case of the mentally retarded, their needs are greater and more complex than those of the average citizen, it is almost a platitude to say that they would be better served if agency programs were coordinated.

However, the fact remains that coordination is almost nonexistent. This is true of all levels of government. For example: In the Department of Health, Education, and Welfare, the Children's Bureau, the U.S. Office of Education, the Office of Vocational Rehabilitation, the National Institute of Mental Health, and the National Institute of Neurological Diseases and Blindness have all received appropriations to increase and intensify their efforts in behalf of the mentally retarded. All of these agencies are making grants to various State departments and to local public and voluntary agencies with little or no clearance among themselves. (See Social Legislation Information Service, Issue No. 33, September 30, 1955, for an account of recent appropriations to the constituent agencies of the Department of Health, Education, and Welfare.) There is a new Federal commission which is charged with responsibility for coordinating research, but, so far as can be determined, there is no coordination of actual program planning, grants-in-aid, consultation to States or other services.

At the State level the departments of correction, education, health, mental hygiene, and social welfare are involved in one way or another in services to mentally retarded individuals but with no formal, recognized integration in planning services or in channeling Federal or State funds to local communities. The nearest approach to coordination is in the mental health commission, which is due to terminate in 1956 unless its life is renewed. This is, however, largely a research responsibility at the moment rather than service. The commission was asked to carry out studies of mental retardation for which funds were appropriated in 1953. It is also concerned with study and evaluation of the experimental classes for the severely retarded which were established in 1954. Obviously, such evaluation is prerequisite to sound planning of statewide policy with respect to the educational needs of the severely retarded.

However, on a practical level the State departments of mental hygiene and social welfare, for example, are expected to set up educational programs for the children in their institutions without supervision by or consultation from the State department of education. Similarly, there is no provision for consultation from the State department of mental hygiene to the State department of education in its operation of special classes either under the old law or the newly enacted 1955 amendment to the State education law, which enables local school districts to establish special classes for the severely retarded.

The appointment of this joint legislative committee on mental retardation is evidence of the need for clarification and coordination. The committee has an unparalleled opportunity to make recommendations bearing on such coordination at the State level.

On the local level there is no official structure to coordinate the various services which might be found necessary for the severely retarded individual. There is no structure which makes the State institution a member of the community which it serves, nor is the institution now expected to participate in the selection of persons to be admitted to its care. It is only after a child finally arrives at the institution that he is fully studied, and it may then be found that he should not have been admitted. Often, too, parents regret their decision to institutionalize a child and may remove him, only to find that they are unable to cope with the situation. For children under 5 years of age there is a long waiting list, although efforts are made to interview the parents in order to help them reach a decision about placement and to determine priorities for admission to Willowbrook (for New York City children). Subsequently, however, many young children may remain on the waiting list for months, even years, until they reach the age of 5 and are eligible for admission to Letchworth or Wassaic. During this waiting period there is no publicly sponsored help available for the parents or for the child whose original referral to a State institution was often based on no more than a psychometric examination rather than comprehensive diagnostic study.

II. Responsibility for early case finding, comprehensive diagnosis, parent counseling, and related services.—The lack of clear allocation of public responsibility in this area is a crucial stumbling block to the development of a sound program. It is imperative that there be provision for early case finding and that a well-rounded diagnostic service be available to all children who are thought to be mentally retarded. Such a diagnostic service must include thorough physical, neurological, psychiatric, psychometric, and social evaluation by qualified personnel working together and with the parents to determine the nature and extent of the disability, its causes, and an optimal program of care and treatment for each child.

It is essential that such diagnostic services be accompanied and followed by counseling to help the parents understand and take appropriate action based on the findings. It is equally important that there be provision for subsequent review of the child's progress and that the parents have access to advice and guidance as the situation in a given family changes from time to time during the life of a severely retarded individual who may be either at home or in an institution.

Differential diagnosis implies the use of a high level of technical knowledge and skill in arriving at an evaluation of a given situation. It also implies the availability of differentiated services as required by the individual. It has been demonstrated that where early comprehensive diagnosis is available for children thought to be intellectually retarded, the findings are often so diversified that a wide range of services is clearly indicated. Among any group of children who appear to be intellectually retarded there will be some who are found to be

psychotic or emotionally disturbed rather than mentally defective; some who are only moderately retarded but so disturbed as to be unable to function at full capacity without psychiatric help; some who are mentally retarded but whose social and emotional adjustment and family situation are such as to warrant the assumption that with education and training they will become reasonably self-supporting, independent members of the community; some with organic conditions amenable to treatment and, therefore, likely to be able to function at progressively higher levels; some whose mental defect is severe but who can, with treatment, education, and/or training, learn to be reasonably self-sufficient within a protected environment either at home or in an institution; and some who will require custodial care for life.

This wide range of diagnostic findings obviously points to the need for a wide range of services. They may include psychotherapy, either ambulatory or inpatient; chemotherapy; neurosurgery; modified recreational facilities; modified educational and training facilities; day care or day hospital services; vocational guidance and training; sheltered workshops; temporary or permanent institutional care; family care; financial or legal assistance; and, in all cases where the individual's mental defect is such as to render him incapable of achieving ultimate responsibility for his own behavior and welfare, there must be available to the parents the services of an agency to which they can turn for help as the situation changes. The use of any or all of these services must, of course, depend on the readiness of the parents, which, in turn, may largely depend on sound professional counseling and support.

Unfortunately, in New York City, and to the best of our knowledge in the remainder of the State as well, there is no provision for a diversified program of this kind. Except as parent groups have initiated them or have stimulated local support for specific services, they are largely nonexistent. There is no provision for the use of State institutions on a temporary basis as part of an ongoing plan which would include, of course, continuing guidance for the parents. There is no provision for day care, training, sheltered workshops, as part of a total program for the severely retarded, and, as we know, the resources of the community which are available to all other children are often closed to these children.

The problem of educational or training facilities for the mentally retarded has received much attention of late. It should not, of course, be considered in isolation since it is one—and only one—of a wide range of interdependent services which should be available for the mentally retarded, but it is a good example of the lack of coordination in our local communities. With the exception of New York City and a few upstate school districts, the education law which requires that special public school classes be provided for the "educable" mentally retarded has not been carried out. Similarly, the implementation of the 1955 amendment to the education law which permits school districts to establish special classes for the severely retarded, often termed "trainable," may well be delayed indefinitely in many school districts even for those who are found to be capable of attending such classes. On the other hand, if there were a coordinated program at the State level it would be possible to provide consultation to local units of government, drawing on the best thinking and experience of education, health, mental hygiene, and welfare to help the local community formulate and carry out sound plans for all the necessary services, including education. Basic to any such plan, of course, is the need for adequate diagnostic facilities which may or may not be available at the local level but could be made available by the State.

As for local responsibility, it is essential that it be fixed in some branch of government which would also have the authority and the funds to carry out such a program. In the opinion of some, this responsibility might be lodged in the local community mental health boards. By law, "mental defect" is one of the "psychiatric disorders" for the care and treatment of which the community mental health boards have been given responsibility. Furthermore, the "rehabilitation of persons suffering from psychiatric disorder"—the social, vocational, and other services likely to ameliorate the effects of the handicap—is clearly spelled out as reimbursable under category IV of the Community Mental Health Services Act. There may be some question as to whether ongoing services of this kind might not place too great a financial burden on the community mental health boards and thereby lessen their overall usefulness to their communities. On the other hand, we know that adequate diagnostic services will screen out of the larger group those who are not actually mentally defective and leave a smaller residue of ongoing cases. We know, too, that in the few clinics which in-

vite such an ongoing relationship with parents the results have been highly satisfactory: Once the initial diagnostic and treatment service and parent counseling and home training program are completed, the parents turn to the clinic only when a valid emergency or serious problem arises. The reassurance that comes from the knowledge that this resource is always available relieves anxiety and insures against the inappropriate use of the clinic's facilities.

III. *Public and professional education.*—Personnel and facilities for the care and treatment of the mentally retarded have long been inadequate. Furthermore, the growth of these resources has lagged far behind that of other public services—for the mentally ill or physically handicapped—and has never been commensurate with the size and severity of the problem. Recruitment of staff has been handicapped by the inadequacies in the field, which in turn are intensified by the failure to attract and hold young people. Until recently appropriations for research and training in this field have lagged behind those in other aspects of health and mental health, with the result that fewer and fewer people are available to serve more and more applicants for service, and except for the relatively few research-minded workers who have persisted in their efforts through the years, research has made little progress.

Furthermore, there is a widespread lack of interest on the part of health and welfare personnel which will not be overcome so long as the current ignorance and aversion to the subject is permitted to continue. Too little is taught in professional training schools of medicine, nursing, social work, and psychology about the range and diversity of emotional, neurological, physical, and social factors to be considered in planning for children who are today roughly diagnosed as mentally retarded. The tendency to lump together all children who are labeled "mentally retarded" is apparent in the general reliance on psychometric examinations as the sole criterion for admission to public schools or institutions. Whereas a "low IQ" should be no more than a signal that full diagnostic study is required, it is all too often considered the equivalent of a diagnosis. The tendency on the part of physicians, nurses, and others either to urge early institutionalization or to advise against it, without giving parents the help they need to make a sound decision, is another symptom of the fairly general professional ignorance. Teacher-training institutions still provide little in the way of preparation for work with the mentally retarded and almost nothing for work with the severely retarded.

A program which is based on sound comprehensive diagnosis, realistic planning, and guidance for parents will provide an opportunity for professional training that should have a salutary effect on the general level of understanding and service. While ultimately it is to be hoped that general hospital and health department clinics and child guidance clinics will accept and provide help for the mentally retarded and their parents, it is too much to expect that this will happen without the stimulation and example provided by specialized services with facilities for professional training. At the same time, efforts must be made to stimulate the inclusion of more imaginative and current material about mental retardation in the professional training programs of the appropriate groups. Experimental programs must be extended and studied carefully and the findings funneled back into the professional training of teachers and other groups who might carry responsibility for programs of education, vocational guidance, training, and supervised workshops, among others. The recruitment problem must be attacked vigorously through the use of all the devices that have been developed in other fields and through specialized incentive programs to overcome the obstacles which are unique in this field.

Public ignorance and lack of interest is, if anything, more extensive than that of professional personnel. The activities of parent groups, locally and nationally have done much to interpret the nature of the problem, but they need the help of professional organizations and public agencies which also have a responsibility for sound public education. A well-organized, systematic program of public education is essential to the achievement of any or all of these goals. The burden which is carried by parents of severely retarded children is very great but its impact can be lessened if their neighbors and fellow citizens are helped to understand and as a result of their understanding provide a community setting which is conducive to the maximum development of which each retarded child is capable. Not only would a successful educational program provide informed public support for more adequate services but also, and equally important, it would provide for the overburdened parents and their handicapped chil-

dren an atmosphere of acceptance and encouragement which is all too infrequent today.

RECOMMENDATIONS

We therefore recommend that the joint legislative committee on mental retardation use its facilities to gather data and where necessary prepare appropriate legislation and/or provide funds to achieve the following:

I. Coordination of public programs and voluntary services to the end that New York State and its local communities may establish and maintain an overall program to meet the needs of all persons who are found to be mentally retarded: Through the good offices of a coordinating agency—commission, inter-departmental council, or some other unit with sufficient authority, personnel, and funds—each State department would be enabled to contribute to the total program from its own area of competence and all would benefit from consultation, clearance, and the establishment of joint programs in areas of mutual concern. Similarly, the relationships of State departments to their own local units and to the units of other departments giving service to the mentally retarded would be greatly facilitated by the presence at the State level of such a commission or council.

II. Allocation of responsibility for early case finding, diagnosis, parent counseling, and related services to the appropriate local unit of government with sufficient authority, personnel, and funds to enable that unit of government to carry out this responsibility: Among the major functions of this unit of government would be the establishment of diagnostic and counseling services either through the expansion of existing facilities or the development of new facilities; the establishment of machinery for the review and evaluation of existing services and the development of diversified new services as required; the provision of ongoing counseling for parents; and coordination of local services. It is understood, of course, that local units would have the advantage of a close working relationship with the aforementioned coordinating agency.

III. Public and professional education, through the combined efforts of public departments, professional groups, voluntary agencies, parent groups, and other citizen organizations who are active in the field: Here, too, the coordinating agency at State level and the responsible units in local communities would be invaluable in spearheading and providing material for public education and particularly for a concerted drive to improve the quality and quantity of teaching about mental retardation in all the professional training schools in the State.

STATE UNIVERSITY OF NEW YORK,
COLLEGE FOR TEACHERS,
Buffalo, November 2, 1959.

HON. CARL ELLIOTT,
Seventh District, Alabama,
House of Representatives,
Washington, D.C.

DEAR REPRESENTATIVE ELLIOTT: In view of my having to cancel my appearance before your committee on October 29, 1959, I should like to write down several of my views on the matter of overall needs in special education as suggested in your earlier letters.

I wish somehow there were a simple, neat, concise package saying, "R—National Plan for Solution of Special Education Needs." As with all problems that people want solved immediately, there apparently is no direct or quick solution. Special education demands attention from any number of services in each State.

The longer that one works in the areas of exceptionality, the stronger becomes his conviction that any operation which attempts to solve problems arising from being "different," must be a well-integrated one which moves into several fields at once. For example, it is not easy to talk about meeting the needs of severely retarded children without asking: Who is to pay for this service? Who is to provide space and teachers? Where does this program fit in the general school provisions for the mentally retarded from 50 to 75 IQ? What implications for the teacher training institutions does such a program imply?—and so on. This small segment of the condition we call mental retardation obviously involves more people and institutions than the school; multiply this by other problems of exceptionality and the magnitude of the problem may be seen.

As we work through an overview of a program it might be profitable to think of the needs of several groups that make up exceptional children. These groups might fall into the following categories:

(a) Those children who will be unable ever to function as adults at private competitive levels.

(b) Those children who, while able to function at a competitive level, come from environments which are so poor that their chances to "make it" are impossible.

(c) Those children who can compete in an independent or semi-independent way with the help of special education facilities.

When one thinks of a program designed to meet the needs of these children, one is led inevitably to the need of developing and maintaining the following:

(a) A continuous and compulsory census similar to that carried out for the blind and deaf.

(b) Some custodial provision for those unable to compete in the work world that we know.

(c) Some training facility for those children who come from environments which depress their chances for success.

(d) Special education facilities—public and private—for those children able to maintain themselves as independent and semi-independent citizens.

In setting up the above, such allied fields that contribute to the solution become vivid: medical services, psychiatric services, school services, institution services, and teacher training services.

Since it is the purpose of your committee to ascertain the "filler" under each of these headings of service, I shall indicate briefly some of the assists which we would hope a teacher training institution could provide with the proper moneys, staff, and facilities:

(a) Education program designed to prepare teachers, attendants, administrators, and workers to meet the needs of the various groups outlined.

(b) Internships and assistantships in the field of mental retardation with allied community agencies.

(c) Research developed from hypotheses of workers and students in the field.

(d) Consultant services to community and State agencies engaged in work in the field of mental deficiency.

While it is always easy to outline a series of objectives to be striven for, it is only fair, for example, to point up that at present our own State does not have an adequate training program for workers or teachers of exceptional children. Of the 11 State colleges of education, Buffalo and Genesee are the only two which offer undergraduate curriculums training teachers for the mentally retarded and speech defectives. Buffalo, in addition, is the only unit of State University which has a program for teachers of children with physical handicaps. This focuses, then, on the major problem in this field—shortages of personnel.

To again use one aspect of the field of exceptionality—mental retardation: In the past 5 years we have graduated from our college only 81 students certified to teach the retarded. The job requests from New York State alone for these candidates has been over 2,318, a shortage of over 2,000 teachers in New York State alone. It is naive to believe that continued shortages will enable us to implement the several goals which are outlined in the field of research, assistantships, consultant services, and well-integrated educational programs without concerted assistance from the State and Federal Government in terms of possibly moneys, facilities, and/or staff.

I suspect, then, what I am saying is that the most crucial pressure that special education faces is not a shortage of ideas and sensible programs but rather a shortage of manpower. I am enclosing a 1958 outline of the problem as I developed it for the New York State Joint Legislative Committee on Mental Retardation. Perhaps after a review of this material by your professional staff there may be further questions I might answer for the committee. I hope you will feel free to call upon me for any further clarification on the materials I have enclosed.

I regret that I could not attend the New York City hearings which I understand were profitable and well attended by several of my colleagues.

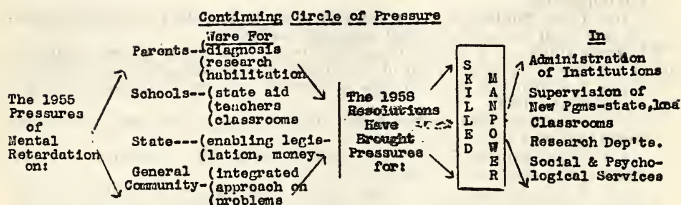
Sincerely,

HORACE MANN, *Director.*

State University of New York
College for Teachers
Buffalo, New York

EXCEPTIONAL CHILDREN! EDUCATION DIVISION

Dr. Morace Mann
Director



Case In Point

Teacher Shortage
1955 - 1958

Job Requests - 1303
Teacher Supply - 44
1259 short

The Years Ahead

Recommended Explorations

Review Pressures for priority action--legislative approach to be overall or pinpointed

Develop legislative commitment for development of personnel program in several fields

Set longterm deadlines for the decade ahead

For Immediate Review in Teacher Education Shortage

Provide recruitment assistance through contracting public relations personnel for development programs

Continue and enlarge scholarship grant program so as to cover not only seniors but freshmen as well

Insist that demonstration centers be established at teacher educating institutions of higher learning

Allocate fellowships for graduate students entering college teaching with exceptional children

STATE UNIVERSITY OF NEW YORK,
COLLEGE FOR TEACHERS,
EXCEPTIONAL CHILDREN EDUCATION DIVISION,
Buffalo, October 9, 1958.

JOINT LEGISLATIVE COMMITTEE MEETING—WHAT NEXT STEPS IN MENTAL RETARDATION FOR NEW YORK STATE?

(By Dr. H. Mann)

I. HEARING OF OCTOBER 28, 1955

A. I outlined several pressures which retardation brought for—

1. Parents: Diagnostic service, schools, research, day care, workshops.
2. Schools: Space, teachers, identification, guidance developmental programs.
3. State: Money, positions, scholarships, institutions, leadership.
4. General community: Research, improved facilities, referral agencies, long-range guidance.

B. Since 1955 the committee has helped to achieve relief from many of these pressures by obtaining—

1. Parents: Relief from institutional liability, permissive education for trainable children, research grants, clinics, 5 to 21 care, removal of "poor indigent" as admission criteria to institutions.

2. Schools: Increased State-aid formula, expansion of cooperative boards, support for psychological services, teacher training relief in scholarship grants.

3. State: Scholarship grants for teacher training, continuing census, permanent joint legislative committee, demonstration centers.

4. General community: Diagnostic centers, institutional crowding relief, research institute for mental retardation, publication of legislative reports focusing and highlighting problems and solutions.

The legislative approach has been a concerted, well-integrated plan for relieving many rather than single points of pressure. Such progress reflects clear and perceptive understanding of the overall nature of the problems arising from mental retardation.

II. WHERE TOMORROW? (1958-PLUS)

A. Nature of pressures remaining (all interrelated):

1. Monetary: New moneys needed for transportation, salaries, services, institutions, buildings.

2. Physical: Enlarged facilities—administrative-institutional, general equipment, and research plant needs.

General (pervasive): Manpower.

B. Which must receive priority in our creative planning?

1. I submit "manpower" as primary.

2. Service ultimately rests in people (for institutions, classrooms, diagnostic centers, rehabilitation workshops, etc.).

3. Appropriations for buildings, plants, research all become empty promise without needed manpower to implement objectives sought.

III. MANPOWER SHORTAGE REFLECTED IN BUT ONE ASPECT OF PROBLEM—TEACHER SUPPLY

A. National picture:

1. Survey (10-year estimate):

(a) 20,000 teachers for educable and trainable.

(b) 2,000 per year needed.

2. Actual graduates of 1953 survey among the 40 colleges training teachers in mental retardation:

Degrees granted:

Undergraduate bachelors 151

Graduate:

Masters 130

Doctors 4

Total 285

Shortage 1715

It should be noted that the estimated number of teachers does not include college needs for teacher educators.

B. New York State picture:

1. 1958 statistics (January):

(a) Educable 1,391

(b) Trainable 93

Total classes 1,484

2. Ten-year projection at 2 percent of total school population in average classes of 15 per class (unknown).

C. Local teachers education picture at Buffalo:

1. General divisional enrollment over 5-year period (freshman, sophomore, junior, senior)

	Majors in all fields of exceptional children	Percent college enrollment	Staff
1953.....	72	3.5	3
1954.....	144	6.5	3
1955.....	149	6.1	3
1956.....	197	7.9	5
1957.....	257	9.9	5
1958.....	306	11.0	7

2. Mental retardation figures, New York State

	Graduated in	Job requests for
1953.....	4	70
1954.....	7	75
1955.....	8	125
1956.....	8	215
1957.....	12	438
1958.....	12	525
Total.....	51	1,448
Shortage.....	1,397	

Vivid evidence that manpower problem remains after much of the legislative progress has been made.

IV. IMPLICATIONS

A. A review of the present overall approach to legislative relief of pressures arising from mental retardation should be undertaken. In short, should we continue to advance on all fronts, inching forward everywhere, or should we concentrate what available energy and moneys are available to attacking the pervasive personnel shortages in all phases of this work—teachers, psychologists, social workers, etc.?

B. A drastic and stepped-up plan will be needed if we are to achieve adequately staffed schoolrooms, in both public and institutional settings, for the mentally retarded.

C. A philosophical commitment regarding the role the State legislature is willing to play in enhancing and promoting existing teacher educating facilities in this field must be thought through so agencies in local communities can plan ahead realistically.

D. A projected plan for the decade ahead should be examined so that achievement deadlines may be explored with a view to planning necessary ameliorative assistance on both State and local levels.

V. POSSIBLE AVENUES FOR IMMEDIATE INVESTIGATION DIRECTLY RELATED TO PERSONNEL SHORTAGE

A. Recruitment assistance—either through direct or contracted subsidy—for developing materials and publicity for high-school persons, college students, and already trained teachers in other fields.

B. Enlarged scholarship program with sufficient funds to dip down to the freshman year for the potentially interested student in mental retardation.

C. Vivid development of demonstration facilities—as the projected day-care centers for the retarded—on the teacher educating campuses so that recruitment, research, and practice may be enhanced. (We are told that by 1968 we will have a special education building.) In short, a way must be devised to bring early enlarged and improved specialized facilities to institutions preparing persons as teachers in this work.

D. The creative arrangement—as was done with Smith-Hughes Act or as with present Federal rehabilitation programs on national levels—whereby the State can subsidize and enlarge teacher education staffs on campuses where limited enrollments do not provide for such personnel on a student-faculty ratio. (Salary competition from public and private schools, research projects, and foundation agencies in this work often make it impossible to win the competitive fight for college personnel.)

ADDENDUM

I am adding the following merely to reenforce the importance of strong action taken soon in the recruitment picture for not only public school teachers but college personnel, too.

Why is recruitment difficult?

I. Nature of task you need done (a teacher training institution in field of exceptional children education should sponsor and develop):

A. Education programs designed to prepared teachers, administrators, and workers to meet the needs of exceptional children.

B. Intern and assistantships in those community agencies engaged in the field.

C. Research from hypotheses of workers and students in exceptional children education or allied disciplines.

D. Consultant services to community and State agencies in need of such assistance.

II. Quality personnel needed to achieve these goals (criteria we use for hiring):

(a) Teaching experience with retarded, minimum 3 years.

(b) Teaching experience in college, 2 years.

(c) Doctorate work in special education (about 8 to 10 years' preparation).

(d) Experience in community and research activities.

• III. What we have to buy with (BSTC):

Rank:

Range

A. Professor----- \$7,206--\$8,586

B. Associate professor----- 5,976- 7,206

C. Assistant professor----- 5,100- 6,210

Neighboring schools often hire our beginning teachers in mental retardation from \$4,700 up.

STATEMENT BY DR. HOWARD A. RUSK, NEW YORK UNIVERSITY-BELLEVUE MEDICAL CENTER

My name is Howard A. Rusk. I am a physician and am professor and chairman, Department of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center; director, Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center; and associate editor, the New York Times. I am or have been associated with a large number of national and international organizations, professional and voluntary, concerned with rehabilitation services for the physically handicapped.

As a physician and citizen, I should like to go on record as being strongly in favor of all the provisions of the Rehabilitation Act of 1959. All of these provisions—evaluation services, independent living, workshops and other rehabilitation facilities, research and demonstration, President's Committee, and extension and improvement—are, in my opinion, sound measures which will contribute substantially to our national goal of providing maximum rehabilitation opportunities for all of our disabled citizens who can profit by such opportunities.

I should like in this statement, however, to confine my remarks to those provisions of the Rehabilitation Act of 1959 pertaining to "Independent Living."

When the Vocational Rehabilitation Act of 1954 was enacted I had the privilege of discussing this extremely important legislation with a great many Members of the Congress, the administration, professional leader in rehabilitation, and interested citizens. At that time I stated both publicly and privately that the next great objective in our national program of rehabilitation should be a program of the kind which would be provided for under the independent living provisions of the Rehabilitation Act of 1959.

I am sure that much of the extreme significance which I attached to these proposals is the result of my experience since 1946 as director of the Physical

Medicine and Rehabilitation Service of Bellevue Hospital and as consultant in rehabilitation to the Department of Hospitals of the City of New York. The Physical Medicine and Rehabilitation Service of the New York City Department of Hospitals is the largest non-Federal service of its kind in the world. The Physical Medicine and Rehabilitation Service at Bellevue Hospital developed in 1946 on the basis of the wartime experience of the Army Air Forces and, patterned on the recommendations of the Baruch Committee on Physical Medicine and Rehabilitation, was the first comprehensive integrated rehabilitation service for inpatients in any civilian hospital in the world. Today within the municipal hospital system of the city of New York there are 9 rehabilitation centers with a total of over 1,000 beds.

Each year these rehabilitation services, which are available to all medically indigent residents of the city of New York, provide comprehensive rehabilitation services for several thousand severely disabled persons who have been determined to lack sufficient vocational potentials as to be eligible for services under the State-Federal program of vocational rehabilitation. But we know from this over 13 years of experience that return to employment is not the only valid goal of rehabilitation. Among our population there are several millions of chronically disabled persons for whom age, extent of disability, or personal desires preclude a return to remunerative employment. But many of these persons can be rehabilitated to the status of partial or complete independent living. It is also apparent that the number of such persons will increase in the future rather than decrease.

Until the last 50 years, the saving of human life as the traditional and cherished goal of medicine was largely a matter of saving individual patients. With the first half of the 20th century, the whole character of medicine's goal changed. The expansion of research into the etiology and therapy of communicable and infectious diseases "struck specifics." The establishment of new and effective public health measures and the rich findings in the basic fields reported elsewhere in this publication gave the lifesaving functions of medicine mass proportions.

These, combined with similar advances in greater availability of medical and hospital care, improved nutrition, increased education, better housing, and all the contributing factors to our unprecedented current standard of living in the developed parts of the world mean hundreds of thousands of persons are alive today who would have died at the turn of the century with the same medical problems.

In 1950, at the end of the first half of this century, a number of our more mature national leaders were asked what they considered the most significant developments that occurred in the first half of this century. With the sagacity which usually marks his comments, Mr. Bernard M. Baruch ranked the prolongation of the lifespan in the United States by 18 years within a period of 50 years as having more implications for this and future generations than such technical developments as improved communication and transportation, mass production techniques, and the development of nuclear energy.

Today we have in our population 15 million persons beyond the age of 65. By 1970 their numbers will have grown to between 20 and 25 million. Life expectancy has increased from 49 in 1900 to 67 in 1950 and today has reached the legendary threescore and ten.

Although the further extension of life expectancy during the next 20 years will not be as great as in the past two decades, the growing number of older persons in our population and the resulting increased incidence of both chronic disease and chronic disability will without doubt be among the most serious challenges facing medicine.

Although the pathology of many of the chronic diseases remains at present irreversible, experience has shown that the social, emotional, and vocational sequelae of these diseases need not be.

Although chronic disability strikes persons of all ages, those in the upper age brackets are its particular targets. Today on every hand we see hundreds of thousands of these older persons who have been allowed to become unnecessarily dependent. These patients are absorbing the services of vast scores of health personnel in hospitals, nursing homes, and in their own homes and of members of their families who could be freed for other essential services if opportunities for rehabilitation for independent living were available to them.

The Commission on Chronic Illness has estimated that on any given day there are about 1,100,000 long-term patients in our institutions. In addition, there

are an estimated 45,000 long-term patients in short-term general hospitals and hundreds of thousands of persons who are confined to their own homes because of disability.

One of the major problems now confronting medicine which will be further accentuated in the next 20 years by the growing incidence of chronic disease and chronic disability is how these services can be brought most effectively and most economically to those patients needing them.

Physicians, hospitals, social workers, community agencies, and families err constantly in the loose interpretation of the term "chronic illness." A recent Government publication states that "In 1950, 17 in every 100 persons aged 65 and over were estimated to have long-term chronic illness, as compared to 3 or 4 percent per 100 among the general population."

Among this 17 in every 100 persons aged 65 and over, there are many who are "chronically ill" in that they require continuing medical services of the type which can be provided only or best within a hospital. Among them, however, are others who are "chronically disabled" in that although they have static physical impairments (such as hemiplegia following stroke), they are not in need of continuing hospital care. But since there is no place else for them to go, they are forced to live for months or years in an environment where pain and death are a part of the daily routine.

This situation was brought into the professional spotlight recently by a study conducted under the auspices of the New York Foundation at Goldwater Memorial Hospital, a municipal hospital of the city of New York. In this study of 95 unselected cases (average age of 68.5 years), it was found after intensive medical, social psychological, and economic evaluation that only 7 were felt to be in need of continuing hospitalization; and 2 of these cases were considerably questionable. Using the customary rehabilitation standards, 11 patients were considered suitable for rehabilitation with a better than 50-50 prospect of success. The remaining 84 of the original 95 patients were considered to be in no need of either rehabilitation or definitive medical care.

An analysis of but three of these patients showed they alone had been cared for in municipal facilities for a total of nearly 19,000 days. Calculating arbitrarily and conservatively at \$12 per day as cost of their care, the total cost of these three patients alone to that point was \$228,000 and the end was not in sight.

This is a sizable sum, but it is only money. What about the cost to these individuals in boredom, anxiety, frustration, and resignation?

If any major attack is to be made on the problems of chronic disability, there must be provisions for rehabilitation opportunities for those disabled individuals who are not considered potential candidates for return to remunerative employment. The provisions of the "Independent Living" title of the Rehabilitation Act of 1959 would make such opportunities available to a substantial number of our disabled citizens. Failure to provide such opportunities will guarantee their continued deterioration until they reach the totally dependent category. The neglect of disability even among persons without vocational potentials is far more costly than an aggressive program which restores the individual to the highest possible level of physical, emotional and social self-sufficiency.

Mr. ELLIOTT. The subcommittee will now recess.

(Thereupon, at 5:20 p.m., the subcommittee was recessed, to reconvene subject to the call of the Chair.)

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SPECIAL EDUCATION AND REHABILITATION

HEARINGS

BEFORE THE

SUBCOMMITTEE ON SPECIAL EDUCATION

OF THE

COMMITTEE ON EDUCATION AND LABOR

HOUSE OF REPRESENTATIVES

EIGHTY-SIXTH CONGRESS

FIRST SESSION

ON

H.R. 1119, H.R. 3465, H.J. Res. 488, H.J. Res. 494

BILLS REGARDING THE FIELD OF SPECIAL
EDUCATION AND REHABILITATION

PART 2

HEARINGS HELD IN NEW HAVEN, CONN.,
DECEMBER 17 AND 18, 1959

Printed for the use of the Committee on Education and Labor



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SPECIAL EDUCATION AND REHABILITATION

THURSDAY, DECEMBER 17, 1959

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON SPECIAL EDUCATION
OF THE COMMITTEE ON EDUCATION AND LABOR,
New Haven, Conn.

The Subcommittee on Special Education met, pursuant to notice, at 10 a.m., in the Federal courtroom, U.S. Post Office Building, New Haven, Conn., Hon. Carl Elliott, chairman of the subcommittee, presiding.

Present: Representatives Elliott (chairman of the subcommittee), Daniels, Giaimo, Wainwright, and Lafore.

Mr. ELLIOTT. The Subcommittee on Special Education is pleased to have this opportunity to meet in New Haven. This is one in a series of hearings that our subcommittee is conducting throughout the Nation.

The purpose of our hearing is to learn at firsthand what America's needs are in the field of education and rehabilitation and to learn how we might best meet these needs.

We are also hearing testimony on specific bills which have been referred to the subcommittee.

The members of our subcommittee who are present today are Mr. Daniels, of New Jersey; Mr. Giaimo, of Connecticut; Mr. Wainwright, of New York; and Mr. Lafore, of Pennsylvania.

At the outset I want to express to Congressman Giaimo our appreciation for inviting us to come to New Haven and for his very fine assistance in making this hearing possible. He and his staff have been most helpful to the subcommittee in this regard.

Mr. Giaimo become a member of our subcommittee last year upon his election to Congress, and he has in this year proven himself to be able and energetic and effective and I personally count it a great privilege to serve with him in the Congress.

At this point I want to recognize Mr. Giaimo to present the mayor of his home city, New Haven.

Mr. Giaimo.

Mr. GIAIMO. Mr. Chairman, members of the subcommittee, it gives me a great pleasure to welcome you to our fair city of New Haven. We hope your stay here will be an enjoyable one and also a fruitful one. It is a real pleasure for me this morning to introduce to you the first witness who will appear before the subcommittee, the mayor of the city of New Haven.

Mayor Lee is an outstanding administrator. He has done a magnificent job in carrying out the affairs and the problems which face this city of ours. He is a young man. His energy and ability are re-

nowned not only in the city of New Haven, not only in the State of Connecticut, but undoubtedly throughout many parts of our Nation.

He is a man who needs no further introduction from me or anyone else. I am proud to be able to present him to you this morning.

Mayor Lee.

Mr. ELLIOTT. Mayor Lee, you may proceed.

STATEMENT OF HON. RICHARD C. LEE, MAYOR, CITY OF NEW HAVEN, CONN.

Mayor LEE. Mr. Chairman and members of the committee, I am very grateful for the opportunity to come here this morning and especially to my neighbor and my representative, Bob Giaimo, for his very kind words.

I would like, first of all, to welcome all of you to the city and to say how glad we are that you are able to be among us for several days and to hope also that your visit will be fruitful and productive.

We are rebuilding our city, as you know. We are attempting, in rebuilding it, to meet the challenge of the 21st century. In so doing we have to sort of dramatize the complex problems of human values which face our people.

I am delighted, as a citizen, and as a public official, to see that Congress is taking such an active interest and active role, as well, in the total problem of special education and rehabilitation. I am sure you recognize that the city officials particularly see these kinds of problems at their most obvious level, which is the municipality.

We know that a great many of the people on our welfare roles, for example, are there because they lack simple training or work facilities which would open the doors of opportunity to them and help them to become productive citizens.

Now, there are many who can speak with far more authority than I on some phases of the omnibus bills, such as opportunities for gifted children which are being denied them now in some measure—the blind and the mentally handicapped.

I do not intend to talk about these this morning because there are other people who will testify, but I would like to talk this morning about the bill which is House Resolution 3465, the independent-living bill, which is before you. It is of special interest to our people because it exemplifies the potential of the investigation which you are conducting now.

Among the bills there are many worthwhile provisions. There is one which would make Federal funds available to localities which have need for sheltered workshop and training facilities. If this section were adopted, it would expand the possibilities for fruitful cooperation among the three levels of Government, Federal, State, and local, and the voluntary welfare agencies as well.

New Haven, for example, has a rehabilitation center which is supported by the United Fund and Easter Seals, an Office of Vocational Rehabilitation, and Goodwill Industries.

But the need for modernization and consolidation and expansion of these facilities is acute. To put it mildly, there are many handicapped people who are homebound and for whom there is no rehabilitation

service whatsoever; and there are many, therefore, whose work potential and work capacity have never even been tested.

Now, New Haven's private and public welfare agencies are attempting to fill this gap to help the handicapped gain new tools and new confidence in their struggle to overcome the social and psychological detriments which multiply their feeling of loneliness, uselessness, and neglect.

The voluntary agencies in New Haven are looking into the future and currently are studying plans on a long-range basis for a central building to house some 15 such community agencies.

Now, we of the city are working with them and we are studying the possibility that the building could well become a part of one of the several redevelopment projects which we have underway here in New Haven. A central building of this type could offer unified work and training facilities for the handicapped all under one roof in pleasant physical surroundings which would offer hope for individual productivity and creative activity.

The bill before you would provide funds to help pay for the rehabilitation wing of such a building as we are considering here in the city.

By expressing the national will to halt the terrible waste of human resources which comes from neglecting the handicapped and by speeding construction of such projects as this rehabilitation wing, the Federal Government would encourage public and voluntary agencies to cooperate for greater efficiency and accomplishment.

This type of frontal assault, I believe, is needed desperately at a time when statistics of rising welfare loads and declining city and State resources are prominent in each day's news.

Congressional leadership and action will be effective reminders to the American people that the handicapped can and should be helped to achieve some degree of independence—that everything possible should be done to help them acquire special skills, which will enable them to take their place with self-respect and give them a fair chance to prove their worth side by side with the ordinary and useful members of our society.

I am delighted again that you have chosen to visit New Haven as you seek practical methods for treating such vital human problems as these. I hope that the meetings of the New England Regional Workshop, sponsored here in New Haven, were of help to you in your study.

Thank you very much.

Mr. ELLIOTT. Thank you, very much, Mayor Lee.

At this time the subcommittee will suspend a moment while the photographers take the mayor's picture.

(A short recess was taken.)

Mr. ELLIOTT. Thank you very much.

The committee will resume its sitting.

May I say to you, Mayor Lee, that we deeply appreciate your welcome and the information that you have brought us which will be very helpful.

Mayor LEE. Thank you very much, Mr. Elliott.

Mr. ELLIOTT. The Subcommittee on Special Education is indeed honored today to have with us a very distinguished and outstanding

Member of Congress from the Second District of Rhode Island, the Honorable John Fogarty. For many years now the programs sponsored by our Federal Government in the fields of public health and rehabilitation and special education have all borne John Fogarty's imprint. His knowledge, his sympathetic understanding, and his effective work in all these fields have earned for him the esteem and the admiration of all of us.

Just recently Congressman Fogarty received the Albert Lasker Award. This award was presented with a citation for his outstanding service in the field of public health. The award was in the amount of \$5,000 and it is no surprise to me that Congressman Fogarty gave this \$5,000 to the parents council of his home State of Rhode Island, to be used in an adult education program on mental retardation.

Congressman Fogarty is the author of two bills now being considered by this subcommittee, H.R. 1119, the independent living bill, House Joint Resolution No. 488, the speech and hearing bill.

Mr. Fogarty, you have honored us greatly with your presence here today. We are happy that you have come. We welcome you to bring the words of wisdom which you always do to us again here in this subcommittee hearing in New Haven.

You may proceed.

STATEMENT OF HON. JOHN E. FOGARTY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF RHODE ISLAND

Mr. FOGARTY. Thank you very much, Mr. Chairman, and members of the committee.

First, may I commend you and your committee for taking time out during a recess of Congress, to get around and find out the thinking at the local level on the problems people have in the fields of rehabilitation and education.

I would also like to commend the committee for their attendance here this morning because, as you know, when congressional committees are traveling in the field the attendance is usually not so good.

But here we have all but one of the full subcommittee and I think that is a real significant way of showing how sincerely interested you are in this kind of legislation.

I do not have to tell your colleagues and I am sure I do not have to tell the people assembled here this morning, of the leadership that you, Mr. Elliott, have provided in all of these fields of health, education, and labor.

You certainly have made a wonderful record for yourself and I'm happy to be able to make the same statement about all the members of the subcommittee.

I would like to make special reference to the member in whose city we are meeting, Mr. Giaimo. I first met him almost a year ago; it was last January, in his first term as Congressman from this particular section.

I am convinced that the main reason you are meeting here in New Haven is because Congressman Giaimo happens to be a member of your committee. To my knowledge he has been one of the hardest working members of the committee and has been doing a wonderful job in Congress.

Now, I just want to say briefly that I am here to say just a few words as to what these bills are and how I became interested in this kind of legislation.

As the chairman has already said, I have been serving on the Appropriations Subcommittee that appropriates the funds for the Department of Health, Education, and Welfare for the past 13 years.

In this capacity I have had the opportunity for many years of asking questions of the Office of Vocational Rehabilitation, the Office of Education, our Public Health Service, and all of our national officials who have some responsibility in those fields.

It was a doctor down your way, Mr. Elliott, down in Nashville, Tenn., who first brought to my attention some 3 years ago the great and crying need existing for trained teachers in the speech defect and hard of hearing field. He was a Dr. Wesley W. Wilkerson, Jr., who has a speech and hearing center in Nashville, Tenn., and he impressed me as being one of the most dedicated men I have found in the entire country.

I was amazed when he told me, at that time 3 years ago, that we had in the neighborhood of some 8 million people in our country suffering from some form of speech defect, or who were hard of hearing in one way or another, that between a million and a half and two million children of school age had some of these defects; that about 30,000 children were born every year with a speech defect or some problem of hearing; and that the tragic thing was that we were graduating only 150 trained teachers a year when we should have been graduating at least 500 teachers a year just to keep current with the problem.

When these facts were brought to our attention we tried within the limit of our legislative responsibilities on the Appropriations Committee to add additional funds for research into those areas of speech defects and hard of hearing. But when it came to providing funds for educating or training teachers, it was found that we needed additional legislation, and that is why you, Mr. Chairman, and I and several others have introduced the bills that we are discussing today; bills that will provide additional teachers to take care of these children.

With your help, you will remember, just 2 years ago we were able to pass a similar bill appropriating a million dollars a year for 10 years to train teachers for the mentally retarded children of our country. That is now in its second year of operation and it is one of the most effective bills in the health area that we have been able to get through the Congress. I think, if I am correct, that it went through by a unanimous vote.

It was a bipartisan measure supported by everyone and I do not think there was a single vote against it.

I hope that we will be able to do the same thing as far as this particular bill we are discussing today is concerned.

Now I would like to make a few comments about my other bill before the committee, the Rehabilitation Act of 1959. I have listened for some 12 or 13 years to Mary E. Switzer, who is doing such a wonderful job as Director of the Office of Vocational Rehabilitation, telling us from time to time that there were many gaps in our present vocational rehabilitation bill. As a result of listening to some of the things she had to say and to some of the representatives of the voluntary agencies

throughout the country when they came before our Appropriations Committee to testify, it became obvious that something had to be done to fill in the gaps in the present act. It was for this reason that we have introduced the bill now under consideration which is called the Rehabilitation Act of 1959.

Now, I am not going to take time to spell out all the details of my bill. You are all thoroughly familiar with it, I'm sure. But I would like to read you one page of my prepared manuscript and then, with your permission, I would like to file the manuscript after which I will be happy to answer any questions there are.

Mr. ELLIOTT. Without objection, the statement of the gentleman will be made a part of the record immediately following his oral presentation.

Mr. FOGARTY. In my opinion, the most important phase of the Rehabilitation Act of 1959, it will have to be changed to 1960 now, is the independent living portion of it. We all know that disability and disease are among the major causes of dependency.

The economic loss resulting from these major causes are again of the greatest magnitude to our economy. With prolonged disability, family earnings are wiped out and families are often broken up. Public assistance and institutional costs are increased.

Essential labor skills are lost to industry and purchasing power and tax revenues evaporate. In human terms the cost is even greater in the loss of pride, dignity, and self-respect.

There are hundreds of thousands of disabled people in the Nation who can become self-reliant through rehabilitation, but who cannot now be served under the existing vocational rehabilitation program because they have no immediate employment prospects.

We need to enlarge the scope of the present program in order to make it possible for these people to receive rehabilitation services to prevent prolonged disability and to enable them to achieve independence at the earliest practical date.

As indicated, dependency is costly in dollars and human values. Independence, on the other hand, means conservation of dollars and self-respect. Every disabled person who is assisted in achieving independence, whether it be independence in meeting the normal needs of daily living only, or in holding and working at a job as well, contributes to society's economic and social well-being.

Whenever we are called upon to appropriate funds for the present Vocational Rehabilitation Act in their grant to State programs we are told that the most conservative figure that the agency has ever been able to gather is that for every Federal dollar that we have appropriated the Federal Treasury has been reimbursed at least on a 10 to 1 basis.

Most of the voluntary groups that have made some study of this particular program seem to think that it is a 15 to 1 return rather than a 10 to 1 return.

As you know, we have never had any problems getting the proper appropriations through Congress because of the wonderful work that has been carried on under the present Vocational Rehabilitation Act. I know that you can see, Mr. Chairman, because of your interest and the interest of the other members of your committee, if we can expand the act as we are proposing now, what a wonderful thing it would be

for every person, whether employable or not, who is physically handicapped to some extent.

It would be an economic gain for our city, our State, and our Nation. I do not think you can count in dollars the moral gain that a person receives when he has received some rehabilitation. Whether it is to just take care of himself so that he does not have to be in an institution or does not have to pay for attendant care, or gives the disabled person a chance to take a job for the first time in his life, I think that effective rehabilitation must be one of the most rewarding experiences that a person like that can have.

After listening to some of these programs for 12 or 13 years now, I think that these people are being neglected on a local and State level and that unless the Federal Government takes the lead and stimulates local communities and the States with programs like this, our disabled people are not going to receive the assistance that they should have.

(The formal statement of Mr. Fogarty follows:)

FORMAL STATEMENT OF HON. JOHN E. FOGARTY, U.S. REPRESENTATIVE OF THE SECOND CONGRESSIONAL DISTRICT OF RHODE ISLAND, IN SUPPORT OF HIS LEGISLATION TO ASSIST PERSONS AFFLICTED BY SPEECH AND HEARING DISORDERS AND TO RESTORE THE PHYSICALLY AND MENTALLY HANDICAPPED TO "INDEPENDENT LIVING"

Mr. Chairman, it is indeed a pleasure for me to have the opportunity to appear as the first witness at these hearings and to discuss the proposed legislation reflected in House Joint Resolution 316, and the subsequent proposal, House Joint Resolution 488, and also H.R. 1119.

The joint resolution, which I have cosponsored with our good friend, Senator Lister Hill, as you know, is intended to make available to children handicapped by deafness the specially trained teachers of the deaf needed to develop their abilities, and to individuals suffering speech and hearing impairments those specially trained speech pathologists and audiologists needed to help them overcome their handicaps.

The bill, H.R. 1119, which I also cosponsored with Senator Hill, is designed to fill gaps in existing rehabilitation services which result in the denial of such services to many physically and mentally handicapped individuals who could benefit from them.

I would like to start off by discussing briefly the urgent need for the speech and hearing bill.

As we all know, there are in the population a large number of people with speech and hearing handicaps—both children and adults—who need special help if they are to function normally in our society. Special services in our country are provided mainly by health, rehabilitation, welfare, and educational agencies, and much could be said about the importance of each of these services. Most essential, of course, is early case finding through health and welfare agencies as well as through the schools, and of especial importance is care of adult citizens including the aged who suffer from impaired hearing. It is necessary for our public agencies at the local, State, and Federal level, in cooperation with private agencies, to provide a balanced program of medical care, education, rehabilitation, and welfare services so that these citizens of all ages who are handicapped by speech or hearing defects can enjoy as full a life as possible and make a maximum contribution to society. On the whole, I would say, services to these citizens are far from adequate.

In discussing this problem and the needs of these individuals illustrations will be drawn mainly from the problems and needs of school-age children and youth since it is obvious that unless our schools offer the best possible corrective help and suitable opportunity for education to these young citizens, later efforts directed toward rehabilitation, employment, and social adjustment will not be fully effective.

Children and youth with speech and hearing disorders comprise the largest single group of handicapped children. It is conservatively estimated that between 1½ and 2 million school-age children have speech or hearing impairments which are severe enough to interfere with their emotional, social, and

intellectual development. The majority of these have speech defects and about one-fourth of them have limited but usable hearing, and are often referred to as "hard of hearing." A relatively small number, perhaps 40,000, are so severely handicapped as to be classified as profoundly deaf.

In a February 11, 1958, report from the Commissioner of Education, submitted in response to a request of the subcommittee of the Committee on Appropriations of the U.S. House of Representatives, it was indicated that about 90 percent of the speech correction, lip-reading instruction, and auditory training for school-age children is carried on in the elementary and secondary schools. However, this type of service needs to be multiplied. There is a wide gap between the number of children and youth needing this service and the number actually receiving it.

The report stated that not more than one out of five of the school-age children requiring speech correction or special instruction because of hearing loss are receiving this. Only about 4,000 speech correctionists and teachers of children with impaired hearing are now in the Nation's schools and about 20,000 would be required.

It was also indicated, that while school programs should be extended and research continued and intensified, the single greatest deterrent to progress is the lack of qualified personnel. Thus, it seems that the goal of serving all of the Nation's children could not be reached without additional well-trained personnel. The task of recruiting and preparing the needed number of speech correctionists and special teachers is so great that without Federal aid State and local school systems and colleges and universities face an all but insurmountable task in attempting to meet this enormous problem. Further, a gap exists in the Federal contribution to the development of personnel in this field. Federal aid is now available for the training of medical and clinical personnel but not for the training of educational personnel.

While the total number of deaf children and youth is small in comparison to the total school-age population, the needs of each deaf child are acute. The major problem which confronts the deaf child is that he cannot learn language in the usual imitative way. This has a tremendous influence on his ability to profit from educational opportunities. The school, therefore, must teach him in a systematic way to develop communication. It also must provide him with the usual school curriculum and the tools of learning. In addition to such educational opportunities, the deaf will need, as they mature, much help from rehabilitation and guidance services. Some deaf individuals may require aid throughout their lives. Given suitable education and guidance, most of the deaf children and youth can develop into contributing well-adjusted members of society.

The task of preparing teachers for the deaf is highly technical and calls for extensive professional preparation. At present, schools face an increasingly critical shortage of qualified educators to work with these children. This is probably partly because teaching the deaf is one of the most difficult of all teaching tasks. It appears that unless more is done through such means as substantial scholarships, it will not be possible to recruit the necessary number of qualified and dedicated educators needed for this field. According to estimates not more than one-third of the number of teachers needed each year are being recruited and prepared. Furthermore, it appears that not enough promising persons are preparing for leadership positions. To illustrate, in 1953-54 not a single college reported awarding a doctoral degree in the education of the deaf.

Legislation directed toward solving the personnel problem in this field will be a step forward toward providing for those with impaired speech and hearing. House Joint Resolution 488 is recognizing the need for qualified personnel to aid the largest single group of handicapped individuals, namely those with speech and hearing disorders. It is also recognizing the critical shortage of well-qualified teachers of the deaf and is suggesting a Federal scholarship program for classroom teachers in this field.

In the case of the deaf, the proposed legislation recognizes a serious human need even though it affects only a small segment of the population. The intent of this legislation is aimed at broadening the scope of Federal benefits to the less fortunate members of our society.

In the matter of the "independent living" bill, as we all know, disability and disease are among the major causes of dependency. The economic loss resulting from these major causes are a drain of the greatest magnitude on our economy.

With prolonged disability, family earnings are wiped out and families are often broken up; public assistance and institutional costs are increased; essential labor skills are lost to industry; and purchasing power and tax revenues evaporate. In human terms, the cost is even greater in the loss of pride, dignity, and self-respect.

There are hundreds of thousands of disabled people in the Nation who can again become self-reliant through rehabilitation, but who cannot now be served under the existing vocational rehabilitation program because they have no immediate employment prospects. We need to enlarge the scope of the present program in order to make it possible for these people to receive rehabilitation services to prevent prolonged disability and enable them to achieve independence at the earliest practical date. As indicated, dependency is costly in dollars and in human values; independence, on the other hand, means conservation of dollars and self-respect. Every disabled person who is assisted in achieving independence—whether it be independence in meeting the normal demands of daily living only, or in holding and working at a job as well—contributes to society's economic and social well-being.

H.R. 1119 would add three new titles to the present Vocational Rehabilitation Act (which would become title I under the bills). The new title II would establish a program of Federal grants to States to help them provide rehabilitation services to handicapped individuals who could not reasonably be expected to become able to engage in remunerative work as a result of such services but who could be expected to achieve independent living.

The new titles III and IV would authorize, respectively, additional Federal grants for the establishment of rehabilitation facilities and workshops, and additional Federal grants for the provision of evaluation services to substantially handicapped individuals. The bill would make several other amendments to the existing act and would also increase the appropriation authorization for the President's Committee on Employment of the Physically Handicapped.

I should like to discuss the provisions of H.R. 1119 in the order indicated above.

TITLE I. MODIFICATIONS TO PRESENT VOCATIONAL REHABILITATION PROGRAM

Title I of H.R. 1119 would, among other things, amend section 3 of the Vocational Rehabilitation Act to provide for the reallocation of extension and improvement funds not taken up in full by any of the States. The fundamental purpose of section 3 is to provide Federal financial encouragement to the States to initiate planned activities to reach out and make better the vocational rehabilitation services to disabled persons without diverting any part of their basic support funds from their ongoing program. I feel that it is highly desirable to have this provision for reallocation so that all funds appropriated for extension and improvement purposes are utilized in the vocational rehabilitation program. Such reallocation is essential for the progressive expansion and growth of the program.

This title would also amend the Vocational Rehabilitation Act to provide that where States qualify for Federal grants for diagnostic and evaluation services under title IV of this bill, the vocational rehabilitation services provided under title I shall not include diagnostic and evaluation services.

TITLE II. INDEPENDENT LIVING REHABILITATION SERVICES

Title II which would be added to the present law by H.R. 1119 would authorize separate appropriations of \$10 million the first year, \$20 million the second, and for subsequent years such sums as the Congress deems necessary to help State rehabilitation agencies with approved State plans to extend rehabilitation services to handicapped individuals who, as a result of such services, can achieve independent living. Independent living is described as "such ability of independent living as to dispense with, or largely dispense with, the need for an attendant, thereby reducing their burden upon others and contributing to their dignity and self-respect.

Annual appropriations would be distributed to the States in accordance with a formula similar to that of section 2 of the Vocational Rehabilitation Act, and matched by the States on a basis similar to that provided for Federal grants under such section 2.

I believe the Vocational Rehabilitation Act should be amended to permit the provision of rehabilitation services for independent living purposes. I am of the firm conviction that many tangible economic, social, and humanitarian values will accrue from such a program.

Never before have so many and such effective means existed for preventing, reducing, and overcoming the handicapping effects of disability. Extended disability means dependency and a continuing drain on families and the resources of a community. Rehabilitation has demonstrated overwhelmingly, that much of the handicapping effects of disability is needless. Not only do we have a great need today to provide rehabilitation services for independent living to the thousands upon thousands of our disabled people who require and who can benefit from these services, but with disability increasing in our growing and aging population we should now establish this program to meet an even greater future need. We should keep in mind, too, that many severely disabled people—including some of our older disabled people—who are brought to a state of independence in meeting the normal demands of daily living will be found to be capable of vocational rehabilitation and will become gainfully employed.

TITLE III. WORKSHOPS AND REHABILITATION FACILITIES

Title III, proposed to be added by H.R. 1119, would authorize appropriation of funds (\$10 million for the first year, \$12½ million for the second year, \$15 million for the third year, and for subsequent years such sums as the Congress may determine) with which the Secretary of the Department of Health, Education, and Welfare would make grants for the construction and alteration of buildings for nonprofit workshops and rehabilitation facilities, for initial equipment of such facilities, and for staffing them for a period not to exceed 2 years.

Such grants would be distributed among the States in aggregate amounts proportionate to their population, and the Federal share of the cost of any project could not exceed \$2 for each \$1 otherwise obtained. The definition of workshops and rehabilitation facilities is generally the same as that contained in the Vocational Rehabilitation Act except that the workshop definition includes provision for employment of persons confined to their homes. The State rehabilitation agencies are required to approve project applications as feasible and necessary for vocational rehabilitation, and are to be granted Federal funds for the costs of this service. Responsibility for the establishment of standards and the approval of each project is assigned to the Secretary.

Currently, the total number of rehabilitation facilities and workshops is grossly inadequate to meet the needs of the handicapped. These facilities and workshops are indispensable tools to our modern rehabilitation processes. They provide the means for evaluating, treating, and training the severely disabled who otherwise could not be effectively rehabilitated.

Some facilities and workshops should be large, some small, some should serve all disability groups, some should serve only selected groups. Regardless of the size of the facility or workshop, each plays an important role in the rehabilitation area it serves.

The disabled people who need the services that rehabilitation facilities can so well provide are the people who are severely incapacitated by the neuromuscular diseases, such as multiple sclerosis and muscular dystrophy; they are the amputees who need proper fitting and training in the use of prostheses; they are the people so crippled by arthritis that they have lost the capacity to work or to look after their personal needs. They are the deaf, the hard of hearing, and people with speech impairments; they are the blind; they are victims of polio; they are the epileptics and the cerebral palsied. In fact, they are all severely disabled people who require a combination of services especially designed to help them regain or achieve maximum physical, vocational, and social capacity.

There are in the United States today about 400 workshops whose programs have rehabilitation content. These workshops fall far short in number in meeting present-day needs. Moreover, few of our communities are in a position to establish without financial assistance the additional workshops that are needed.

Modern rehabilitation workshops are required in large numbers for the rehabilitation of thousands of our people who are disabled in many ways. These workshops are especially needed by the mentally retarded and the mentally ill. In these workshops the mentally retarded can be taught fundamental work habits and job skills commensurate with their abilities so that they become independent working members of society. It is estimated that there are over one-half million mentally retarded adults of working age in our society who have never had an

opportunity to work and who, therefore, are dependent upon their families, friends, institutions, or other public resources for their support. Most of these people need workshop services in order to work.

Individuals who have recovered from a mental illness, particularly those who have been institutionalized, often need workshop training and experience to recover lost skills, to build up work tolerance and above all to regain confidence in themselves so that they are secure in their work and social relationships.

Many older disabled workers with multiple disabilities need the services of workshops in order to return to work. Quite often the older disabled worker requires extensive reconditioning services before he is able to return to the competitive labor force. Some older disabled workers will not be able to return to their customary jobs. They are, nonetheless, enabled by the dramatic advances in medicine to live on for many years. Within their limitations, they still have a lot to contribute if they can be given opportunities for productive work on a part-time basis, or on a full-time basis in sheltered workshops, or under other special conditions. There are in our population today about 50 million people who are 45 years of age and over. As this number increases the problem of the older disabled worker will become even more acute than it is today. Many hundred additional workshops are needed to meet present needs, to say nothing of future needs.

TITLE IV. REHABILITATION EVALUATION SERVICES

Title IV, which H.R. 1119 would add to existing law, would authorize the Federal Government to pay two-thirds of the cost, including administration, which the States incur in evaluating the nature and extent of the disabilities and the rehabilitation potential of substantially handicapped individuals applying for vocational rehabilitation services under the present Vocational Rehabilitation Act or for independent living services under the proposed new title II.

The key to success in the rehabilitation of severely disabled people is the adequacy of the diagnostic and evaluation services that are provided.

The diagnostic process for the paraplegic, the quadraplegic, the epileptic, the hemiplegic, the amputee, the emotionally ill, and others who are under severe complicated physical and mental handicaps must be in greater depth and breadth than the diagnostic and evaluation procedure for the less severely disabled.

For example: A paraplegic must have the following tests, examinations and evaluations, upon which to base a prognosis for rehabilitation: (a) a complete general physical examination; (b) a complete neurological examination to determine the degree of paralysis and the level at which paralysis exists; (c) a complete urological examination to determine kidney and bladder functions; (d) complete psychological examinations and preferably a psychiatric examination, because the emotional trauma accompanying this severely disabling condition is of a most serious nature; (e) a complete vocational exploration, because it is not likely that the paraplegic will return to the kind of work he had before; (f) a complete social evaluation. With a condition as severe as this, family and social relationships change. Evaluating the strengths and weaknesses in the disabled person's family and social relationships is essential in determining his rehabilitation prospects; (g) examination by a specialist in physical medicine and rehabilitation, who, among other things, coordinates his findings and all of the other medical findings described above and who sets up the physical regime for the patient. This would include physical and occupational therapy, prevocational exploration, etc.

All of these tests, examinations and evaluations should be done by all these experts, working in concert and as a team. These specialists can best work together as a team in specialized facilities, principally in the comprehensive rehabilitation facility, which offers the best means and resources for bringing them together.

An examination of this kind is in marked contrast to the diagnostic and evaluation services required by less severely disabled persons. For example, a person with a mild hemiplegia, or an arthritic, might adequately be evaluated by the family physician, the physical medicine specialist, the vocational counselor, utilizing certain psychological tests and the social worker.

There is urgent need for special provision in Federal legislation for comprehensive diagnostic evaluation services for the severely disabled which title IV of my bill would provide. This will accomplish the following ends:

(a) It will give greater assurance that more of the people who need such evaluations will receive them.

(b) It will provide States the incentive, stimulation and money they need to provide more of the severely disabled with these comprehensive examinations.

(c) Although expensive at the beginning, in the long run it will result in economy—there will be more successful rehabilitations of the severely disabled and fewer failures.

(d) It will result in sounder expenditure of both Federal and State rehabilitation funds for training and other restorative services.

(e) It will result in more economical use of the vocational rehabilitation counselor's time and the time of other officials of State agencies—hence, it will result in more efficient and economical administration.

(f) It will mean greater use of rehabilitation facilities.

Research and training

Section 5 of my bill would amend section 4(a)(1) of the present Vocational Rehabilitation Act to eliminate the requirement that sponsors of projects for research, demonstration, training, traineeships, and the establishment of special facilities and services, pay a part of the cost of such projects. I believe that the "part of the cost" condition in existing law is unnecessary and burdensome upon both the sponsors of projects and upon the administering agency. In other programs that do not have this condition, sponsors contribute to the cost of their research and training projects. Moreover, elimination of this requirement would bring the conditions of the vocational rehabilitation research and training program in line with the conditions of other research and training programs, both within and without the Department.

President's Committee on the Employment of the Physically Handicapped

Section 6 of H.R. 1119 would increase the appropriation authorization for the President's Committee on the Employment of the Physically Handicapped from \$225,000 to \$300,000. This committee, an independent agency of the executive branch of the Government, seeks constantly to secure greater job opportunities for our physically handicapped men and women. This increase in the appropriation authorization is necessary in order that the committee may continue its vital and excellent work.

In conclusion, I should like to reiterate my deep conviction of the urgent need for a rehabilitation program for independent living, for a facility and workshop program and for a diagnostic service program such as my bill would provide. I believe further that the programs encompassed by H.R. 1119 will enhance America's humanitarian and economic march of progress.

Mr. ELLIOTT. Thank you, Congressman Fogarty.

You do our subcommittee honor by bringing us the great wisdom that you have acquired in this field.

I personally felt very good when I learned you received the Albert Lasker Award this last fall and that was underscored, too, by the fact that a native of my home State, Senator Lister Hill, was chosen for that award, as well.

Mr. Fogarty, to put it very briefly, is the reason behind many of the fine appropriations in recent years for work in the fields about which he has testified. He is recognized all over the country as the outstanding expert not only in the field of legislation, but in the field of appropriations as well. We are happy to have the benefit of his testimony.

Thank you very much, Mr. Fogarty.

I have been told that the judge does not want any smoking in this courtroom and it seems that it falls to my lot to bring the bad tidings. I have to tell the people that they cannot smoke and I have to tell my friends of the press that they cannot take pictures and so on, but that is the way it goes.

Our next witness is Hon. Emilio Q. Daddario, a Member of Congress from the First District of Connecticut. Mr. Daddario has a prepared statement. You may proceed, Mr. Daddario, in any manner

you see fit. You may testify from your statement, or you may summarize it.

If you care to summarize it, then the statement in full will be made a part of the record when you have completed your oral presentation.

Let me say on behalf of the subcommittee that we are happy to be in your State and we are happy to have the benefit and privilege of your testimony.

It is a pleasure to serve in the Congress of the United States with Mr. Daddario and we appreciate his interest in the subjects that this committee is devoting its time to now.

You may proceed, Mr. Daddario.

**STATEMENT OF HON. EMILIO Q. DADDARIO, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF CONNECTICUT**

Mr. DADDARIO. Mr. Chairman, I welcome you and your committee to the State. We here in the State of Connecticut are especially interested in the matters with which your Subcommittee on Special Education deals.

Mr. Chairman and members of the subcommittee, I am appearing here today to support proposed legislation you are considering to ease the critical shortage of trained teachers of the deaf in the United States.

I represent Hartford County, a district which is proud to be the home of the first permanent institution of its kind for the schooling of the deaf to have been established in the United States. That is the American School for the Deaf in West Hartford, which opened its doors in 1817 at the initiative of the Reverend Thomas H. Gallaudet.

The special educational problems in this area have long drawn the sympathetic and serious attention of people in my area.

The shortage of trained teachers of the deaf is not a new problem. To to extent, it parallels the growing need for teachers to meet the general educational crisis anticipated in this country.

The preamble to House Joint Resolution 494, sponsored by Mr. Elliott, states the problems succinctly and well.

There are, however, a number of facts which should be considered in your deliberation. I should like to highlight some of these, and then offer the rest of the statement for the record.

The toll of neglected physical disability is high in any society. In an age when we must make full use of our resources and talents to improve our standards of living and guarantee our survival, it would be a disaster to let ability wither, or to permit, through inaction, indifference to shape and mar the lives of many afflicted by partial or total deafness through no fault of their own.

We Americans believe devoutly in the positive worth of the individual. We must, if we are to meet our own standards, do everything to see that opportunity is extended to every individual on equal grounds.

By the nature of the problem we face, that means special education to correct physical disability. There are just as many gifted children among the hard of hearing as there are among those with normal hearing.

We must make every effort to let them be identified and let them make their contributions to our future.

As a member of the Science and Astronautics Committee, I am especially conscious of this problem in two of its aspects:

I know how seriously we need to find young scientists and see that they get the training necessary to participate in our technological advances.

I know, too, how important research is to the cure and prevention of more serious national disability.

Neither of these aims will be achieved through inaction. For every Edison who surmounts difficulties to enrich this Nation, how many talents have been lost through inadequate care and attention in the schools?

This is not, of course, a local problem. It is a national problem. We know that children with hearing problems fail school four times as often as children with normal hearing. They repeat grades at a cost to taxpayers of some \$20 million a year.

Across the country, it has been estimated that 3 to 5 million school-children need help in the areas of speech or hearing.

At present, scarcely more than one in five school-age children who need the attention of a speech correctionist are receiving it.

Not more than 4,000 speech correctionists and hearing specialists are estimated to be working in the Nation's schools, and they have varying qualifications.

Your proposed legislation notes that it is believed that some 20,000 such specialists would be needed to staff a fully developed remedial program.

Throughout the country varying efforts are made to locate and correct speech and hearing problems. In Connecticut State law requires a physical examination for each schoolchild every 3 years which should include a hearing test.

Larger communities conduct their own hearing examinations. The State department of health supplements this schedule with a traveling team of two audiometrists who visit schools and medical and hearing clinics, measuring the hearing of pupils between ages of 3 to 21.

The highest incidence of loss of hearing appears to be found in the age brackets from infancy to 9 years.

The State will test at the request of communities, or on special directions of certain State authorities."

A third type of program is aimed at checking nursery school children in the Hartford area. In 1958 the State department of health team referred some 163 Connecticut children for examination on the basis of a suspected hearing loss. Twenty-one of these were pre-schoolers preparing to enter kindergarten and 142 were already in the schools.

By medical and educational methods, these children once identified can be assisted to achieve a greater benefit in their formative years than they would otherwise.

Many of the people with a slight loss of hearing often grow up without realizing their handicap. The most serious effect of this disorder is that ordinary communications between persons are interfered with; pupils do not receive the full impact of instruction and are often suspected of being backward for the lack of it.

The individual's sensitivity is likely to be affected, with an effect on the personality in these youthful years. The full warmth of family life is lost, and the child does not attain the satisfaction he might.

We in Connecticut believe that a program such as ours is most necessary. It is, however, unfortunate, that there is no uniform program to detect hearing loss in the entire country, nor any organized program to assure referral of children.

I know of many who feel that the rescue of one child from a misinterpretation of his hearing difficulties is well worth the effort spent.

Consider, however, the problem of the children who are determined by medical means to need special care and training. Here we run up against the critical shortage of trained teachers in the special schools today. Throughout the United States and Canada, qualified personnel are scarce. Positions are open in public and private residential schools, day schools, and day classes as well as in institutional speech and hearing classes.

Some 25 teacher training centers meet the standards of the profession for preparation of additional teachers, but are not pressed by applicants.

A teacher of the deaf needs many special skills. In addition to regular teacher training, for classroom work, he or she must have special abilities to work with hard of hearing children. He or she must teach the child the basic skills of understanding the spoken language, speech reading, how to use speech and language to make yourself clear. He or she must know the problems of communication that the child is experiencing.

He must be able to explain the individual's difficulties to an often bewildered child or parents, teachers, principal, nurses, guidance counselors, and other school personnel, and he must work hand in hand with other school personnel in shaping programs and curricula.

He must have a good working relationship with medical or scientific personnel, such as the therapists, psychologists, and psychiatrists.

He must be able to administer the necessary hearing tests and to interpret for the public the total impact of such a program.

The teacher recruitment problem has been under discussion for many years. The hearing which this subcommittee is holding is performing a valuable service, I feel, in bringing this discussion to the attention of the public, and in spotlighting the need.

The latest figures I have seen show that about 150 persons are now in training to become teachers of the deaf by next fall. The estimates show that at least 500 qualified replacements will be needed in existing schools at that time.

The gap must be made up, as it has in the past, with untrained teachers, with a consequent loss in effectiveness in the education of this group. The need is self-evident.

I wholeheartedly urge that this subcommittee recommend legislation to meet it.

MR. ELLIOTT. Thank you very much, Congressman Daddario, for a very fine and a very helpful statement. We appreciate the trouble you have been to to bring it to us.

MR. DADDARIO. It is a pleasure to be here, as I said before, and of course, to have the opportunity to meet my colleague, Mr. Giaino. This is a small State, but he and I have not crossed paths since Congress adjourned in September.

MR. ELLIOTT. What is your town, Mr. Daddario?

MR. DADDARIO. Hartford, Conn.

Mr. ELLIOTT. Thank you very much.

Mr. Daddario we will be happy to have you sit with our subcommittee at any time during the day that you may find time to do so.

Mr. DADDARIO. I appreciate that, Mr. Chairman.

Mr. ELLIOTT. Our next witness today is Miss Gertrude Norcross, executive secretary of the Connecticut Society for Crippled Children and Adults, of Hartford, Conn.

Now the committee will suspend a moment while our friends from the press remove their cameras.

(A short recess was taken.)

Mr. ELLIOTT. The committee will resume.

Our next witness is Miss Gertrude Norcross.

Miss Norcross, we are happy to have you.

Let me say now that we have for today 28 other witnesses. It is necessary that I confine each witness to 10 minutes.

With that in mind, may I say to you, Miss Norcross, that you may proceed to read your statement if you wish, or you may summarize it and let it be made a part of the record after your summary has been completed, but in order to hear 28 witnesses, which is 280 minutes, even at that rate we will have to move along.

So you may proceed, Miss Norcross, with that understanding.

STATEMENT OF MISS GERTRUDE NORCROSS, EXECUTIVE SECRETARY, CONNECTICUT SOCIETY FOR CRIPPLED CHILDREN AND ADULTS, HARTFORD, CONN.

Miss NORCROSS. Thank you very much, Mr. Elliott.

I don't think I will need more than 5 minutes to present what I have to say at this time.

I am here today representing the Connecticut Society for Crippled Children and Adults. This nongovernmental agency, over a 24-year period, has provided a great deal of the leadership in this State to improve the services available and needed for the crippled people of this area.

It is, therefore, a privilege and an honor that we have been given this opportunity to present to you briefly a few suggestions as to how the Federal Government might assist, to a greater extent, the work which the governmental and private agencies in Connecticut are now carrying on to the best of our ability.

The Society for Crippled Children and Adults is a part of the Easter seal movement within the United States which receives leadership and help through our affiliation with the National Society for Crippled Children and Adults. This society has already indicated to you its interest in H.R. 3465, H.R. 1119, and S. 772, the bills which I would like to discuss briefly as they affect our various programs in Connecticut.

The Easter Seal Society in Connecticut since its incorporation in 1935 has had as one of its aims working with the governmental agencies to provide those services not currently available through tax supported programs or those which it has been mutually agreed should be developed through voluntary funds.

As a result, we now have in this State a network of five rehabilitation and/or treatment centers including four sheltered workshops which have been started with Easter seals funds. There are other local

programs which Easter seals have helped to start as a cooperative effort with other agencies.

We also have a homebound craft service reaching a limited number of patients, a recreational program for the severely disabled, including two day camps and a resident camp, and a rather extensive program of social services.

You might wonder if one agency in a relatively small State has these facilities why we are interested in expanding them, or what our plans might be.

As a matter of fact this society alone served over twenty-four hundred serious involved patients last year and we feel that we are just scratching the surface.

Many of these people were sent to our facilities by the governmental agencies for evaluation, all types of therapy, preemployment and employment assistance.

Many others, however, come to us who could not qualify for public help because they were not eligible for the present vocational rehabilitation service.

These include handicapped homemakers to a great extent, those with questionable diagnosis and no vocational objective, and the very large group of seriously disabled who might be helped in a sheltered workshop or at home to become more independent and able to care for their own needs more effectively.

We would hope that your definition of the handicapped could include these groups as well as those currently in institutions or needing an attendant.

We, as a private society composed largely of volunteers who have seen the need and have organized these facilities and hired the staff to carry out the objectives of the society, are not in a financial position to carry the complete burden of this seriously disabled group.

We feel our experience over the years has demonstrated the need and we feel reasonably competent to carry on the program which we now have and which we contemplate.

From the standpoint of financing the patients, the governmental agencies have been lacking in funds for case services to help us and lacking in staff to make the necessary decisions to find the patients and make the referrals to our facilities.

At the same time, this shaky financial picture has prevented our own trustees from taking the necessary steps to provide the services which we know are lacking—particularly in eastern Connecticut.

We would hope that a careful review would be made of the needs to expand existing facilities before undertaking the establishment of new ones.

As an organization interested in all ages and all types of disabled people, we hope that you will each personally review the substantiating data which will be presented to you in these hearings. We urge the Federal Government to help our division of vocational rehabilitation receive the funds which are needed, both on a case service and administrative level, to allow them to assist the handicapped of Connecticut the way the help is needed.

Thank you.

Mr. ELLIOTT. Thank you very much.

Are there any questions of Miss Norcross.

Thank you very much, Miss Norcross, for your very helpful statement.

Our next witness is Dr. William J. Sanders, the commissioner of education, State board of education, Hartford, Conn.

Dr. Sanders, we are very happy to have you. You may proceed in any manner you see fit.

Do you have a written statement, Dr. Sanders?

STATEMENT OF WILLIAM J. SANDERS, COMMISSIONER OF EDUCATION, STATE BOARD OF EDUCATION, HARTFORD, CONN.

MR. SANDERS. Yes; I have, Mr. Chairman. I shall be happy to submit this.

MR. ELLIOTT. If we could have a copy for the members as we go along, it will be helpful.

MR. SANDERS. I appreciate very much the opportunity of being able to make this presentation to the committee and certainly am very happy that Congressman Giaimo was able to bring you to Connecticut for this hearing.

First, I would like to make the statement with respect to H.R. 3465, the independent living bill.

The Connecticut State Department of Education favors H.R. 3465, a bill which will provide for the extension of rehabilitation services to severely handicapped persons not heretofore eligible and assist in the establishment of public and private nonprofit workshops and rehabilitation facilities.

Under the existing act, the State department of education, through which the office of vocational rehabilitation works, has many more referrals for service than can be handled, due to the lack of funds available. This is in spite of the fact that Federal contributions to this program have increased from the amount of \$276,169 in 1955 to \$327,450 in 1959, and that the State's contribution to the program has increased from \$150,191 in 1955 to \$250,096 in 1959.

During the current year 5,000 persons were seen by our counseling staff, but our estimate is that there are 26,000 persons in the State who need rehabilitation service.

We believe it is of the utmost importance that rehabilitation not only result in employment but that it brings the handicapped who will not be employed to care for themselves and for their homes.

The sheltered workshops and rehabilitation centers in the State and several developed recently, are not large enough or sufficient in number to meet the growing need for them. Federal grants-in-aid should be available to strengthen existing facilities and make the establishment of additional ones possible.

I would like to say also that we favor the bill as it is written without any changes unless, of course, the appropriations should be increased.

With respect to Joint Resolutions 316 and 494, which I have also been invited to comment on, I should like to make some remarks about the situation in Connecticut.

The statement which follows reflects the status and needs of public school education in Connecticut and in the areas of speech and hear-

ing education. The Connecticut State Department of Education favors House Joint Resolutions 316 and 494.

STATUS AND NEEDS OF 1959-60 SPEECH AND HEARING SERVICE

The most recent White House Conference on Education estimated that 5 percent of the school population have speech and/or hearing handicaps. This report on status and needs in Connecticut is based on this rate of incidence.

1. In Connecticut public schools, 22,885 children have speech and hearing problems.

2. Thirty-five percent, or approximately 8,000 children, are now receiving special speech and hearing instruction in Connecticut public schools.

3. Sixty-five percent, or 14,875 additional children, could benefit were such services available.

4. Eighty speech teachers now provide services for the 8,000 children.

5. One hundred and fifty additional speech teachers are needed now to provide services for the 14,875 children.

6. Ten additional speech teachers are needed now to meet speech needs of the mentally retarded children.

7. A total, then, of 160 additional speech teachers are needed now in Connecticut public schools.

These data do not include the 3,965 children who could benefit from speech and hearing services were such services available in parochial schools. An additional 40 teachers would be needed to meet this need.

NEEDS OF 1965-66 SPEECH AND HEARING SERVICES

1. Five thousand seven hundred and sixty-seven additional children—over estimate for 1959-60—will need speech and hearing services in 1965.

2. Fifty-eight additional speech teachers will be needed to work with these 5,767 children in 1965.

3. Twenty additional speech teachers will be needed to work with mentally retarded children.

4. Thus, 318 speech teachers will be needed in parochial schools in 1965.

5. Seventy additional speech teachers will be needed in parochial schools in 1965.

6. A total, therefore, of 388 speech teachers will be needed in the public and parochial schools in 1965, or 308 more than are employed in 1959-60.

The State department of education now operates Mystic Oral School for the Deaf, Mystic, Conn.:

1. A 64-percent increase in enrollment took place during the past 6 years; present enrollment 139.

2. Twenty-seven children are on the waiting list because of lack of teachers.

3. Nine classroom teachers are needed now and cannot be found.

4. One audiologist is needed for hearing evaluation of pupils upon admission and for systematic retesting and for advice in fitting of hearing aids.

STATUS OF HEARING TESTING IN CONNECTICUT PUBLIC SCHOOLS

In approximately 60 percent of the Connecticut public schools, the only hearing test given is the pure tone screening test. Although school nurses and others doing hearing testing realize the need for a threshold hearing test to be given before referring a child to an otologist, in many of the local school systems there is no one qualified to give this test.

If a reliable threshold test can be given in all local schools periodically, the child with a hearing impairment can be identified early and referred for further examination.

Recommendations: From the data that has been presented it is apparent that the most critical need in this area is to increase as quickly as possible the supply of speech and hearing teachers.

We feel it is necessary that there be Federal funds available to provide financial assistance through scholarships for needy students who are pursuing training in this area and to assist colleges and universities to expand or initiate training programs for speech and hearing teachers.

At this time in Connecticut there is such a program at the Connecticut Southern State College and at the University of Connecticut, but there does need to be encouragement for people to come into this program.

I have an additional statement which I will just mention and file with you, if I may. This is with respect to the needs in the field of the emotionally disturbed and mentally handicapped. I should like to compliment Congressman Fogarty and this committee and the Congress on the excellent bill relative to mental retardation and to assure you that we are taking advantage of this bill in this State through preparing people for teaching the mentally retarded.

I do have some material on the socially and emotionally maladjusted. It is hoped we can get help in this direction also.

The Connecticut Assembly last year passed a bill recognizing the need for assistance to such people. Only a slight appropriation was made, but at least the bill is on the books. We do need Federal support in order to encourage improvement in this very important area, but I will not speak any further on this. I will just hand this material to the committee.

Mr. ELLIOTT. Without objection, the additional statement of Dr. Sanders will be made a part of the record at this point.

Thank you very much, Dr. Sanders. We appreciate your kindness.

At this point I would like to read for the record a telegram from the Honorable Edward P. Boland, a Representative in Congress from the Second District of Massachusetts:

Regret previous commitments preclude my joining you for hearing on our House Joint Resolutions 494 and 503 to make available more specially trained teachers of deaf, speech pathologists, and audiologists. Some 500 additional teachers are needed now to alleviate national shortage teachers of deaf children. At least 500 more needed each year in future. Only 125 teachers trained this year while there are 30,000 deaf school age children. These children will grow up to become useful productive citizens if they can obtain proper special education. The States have no training facilities to provide properly educated teachers of the deaf. I believe this must become Federal responsibility to establish a program of grants-in-aid to nonprofit educational institutions to cover cost of courses and establish scholarships for qualified persons. Two witnesses from

my congressional district who are keenly interested in this legislation will testify before you today, Principal George T. Pratt, of the Clarke School for the Deaf, Northampton, and John E. Swan, of Springfield, president, Clarke School Parents Conference. I know they are in a position to give this committee detailed and enlightened information on the need for this legislation.

EDWARD P. BOLAND,

Second District, Massachusetts, Member of Congress.

Our next witness is Dr. Elwyn M. Smolen, medical director, Child Guidance Clinic of Greater Bridgeport, Bridgeport, Conn.

While Dr. Smolen testifies, I will ask the gentleman from Connecticut, Mr. Giaimo, to preside over the subcommittee.

STATEMENT OF ELWYN M. SMOLEN, MEDICAL DIRECTOR, CHILD GUIDANCE CLINIC OF GREATER BRIDGEPORT, BRIDGEPORT, CONN.

Mr. SMOLEN. I should like to begin my statement by expressing my thanks to the subcommittee, both as an individual taxpayer and as a professional in the field of child guidance and community psychiatry.

As a taxpayer, for the painstaking care and diligence with which the subcommittee is pursuing its objectives, and as a professional for the opportunity to discuss some of the unmet needs in the fields of rehabilitation and special education, needs which daily limit and frustrate our efforts in these areas.

My presentation shall be primarily from the viewpoint of a community child psychiatrist and will concern itself with some aspects of mental illness and emotional disturbances as they are involved in the area of rehabilitation and special education.

From this point of view I should like to briefly outline a number of areas of concern which I believe might tend to become less prominent as the committee continues hearing testimony concerning needs specifically and exclusively related to the major aspects of its inquiry.

I believe strongly that the problems I shall mention must be dealt with if any contemplated expansion of rehabilitation and special education service is to be fully effective. They are inextricably involved with such services and yet, not being specifically so titled, might not receive the attention and support they so desperately require.

The first area of concern is the school, more specifically the preparation of teachers to deal with emotionally or physically handicapped children, especially the emotionally disturbed child.

In any handicapping condition there exists a range in the degree of severity from minimal to severe, with the greatest number in the lesser degrees of handicap.

The most severely handicapped—or emotionally disturbed in my particular sphere of interest—become primarily problems for therapy and are thus really not available for school or educational services, until the extent of the disturbance has been diminished by means of treatment.

The moderately handicapped or disturbed children may have their needs met best through special education programs for which teachers are specifically trained—or should be.

However, the largest group remains the less seriously and minimally handicapped and these are almost always included in the regular class program of the school.

I submit that the selection and training of teachers is completely inadequate to equip them to deal helpfully and constructively with these children.

Furthermore, it is from the ranks of these same teachers that the special educators are developed.

I would, therefore, respectfully suggest to this subcommittee that the following, or similar, steps, might be taken to assist in improving this situation:

1. That the Office of Education be directed to conduct a nationwide study of curriculum and content of teacher training programs with the objective of developing suggestions and recommendations as to ways of enriching curriculum content, and teacher preparation, so that future teachers will be better equipped to deal with this aspect of their daily classroom duties.

2. That special funds be made available to teacher training programs to extend the range of summer and graduate courses so as to include both didactic and practicum work in these pertinent areas, and that scholarships be provided for practicing teachers to encourage them to take these courses.

3. That there be increased utilization of the joint education-mental health workshops such as have been held in various States in order to further integrate these fields and improve practice at the local community level.

This may only require additional funds within existing legislative machinery available to both the Office of Education and the National Institute for Mental Health.

The second point I should like to make is that any intensification of efforts in the fields of rehabilitation for independent living and special education for emotionally disturbed or mentally ill patients must inevitably involve greatly increased demands for diagnostic, consultative, and treatment services from existing psychiatric outpatient clinics, particularly for children.

These outpatient clinics are already unable to cope with existing needs for such services. To plan for additional demands without providing the means for increasing such services would be somewhat analogous to building an elaborate two-lane driveway from a one-room shack to a public highway.

If this is true of such services specifically designed for emotionally disturbed and mentally ill patients, it is even more true if we consider that the rehabilitation of any handicapped individual must include some consideration of psychological and emotional factors.

In our own clinic, for example, we have been regularly receiving requests for the evaluation of children with asthma, epilepsy, other neurological conditions, orthopedic handicaps, cerebral palsy, mental retardation, diabetes, et cetera.

I might also add that a very active source of referral to our agency is the local speech and hearing clinic where it has been found that a large percentage of speech disabilities are primarily emotional in origin.

From our point of view, to increase rehabilitational and special educational services to these various groups would only add to an already large and ever growing backlog of unmet requests for diagnosis, consultation, and treatment services, which are, in reality, unavailable.

Existing shortages of outpatient psychiatric services to children, and adults, result from two factors:

Lack of trained personnel and lack of adequate funds.

Shortages of psychiatrists, psychologists, and social workers might be partially alleviated in two ways:

First, by greatly increasing and strengthening existing training programs and stipends to trainees, as well as possibly providing funds for expanding training institutions.

However, this in itself would not be enough. I know of excellent training positions in all three professions mentioned which are going begging because of a lack of applicants. Therefore, it would seem to be necessary to provide Federal support, both financially and perhaps even utilizing Federal personnel, to assist in developing widespread and aggressive recruiting programs at both the high school and college level, even, perhaps, including undergraduate scholarships for those who are going into these fields.

The second shortage, that of funds with which to expand service, might be met within the existing legislative framework by providing additional funds to the National Institute for Mental Health specifically earmarked for this purpose. These funds, in turn, to be allocated to the mental health authority in each State for distribution among various clinics in the State.

On this particular point, the shortage of existing psychiatric outpatient services, I would only like to add that, if the subcommittee is planning legislation in the fields of rehabilitation and special education 2 years hence, it then becomes imperative that some action be taken as soon as possible to strengthen psychiatric services.

We know from sad experience, that if funds were made available tomorrow to expand psychiatric services to any significant extent, they could not be utilized fully for at least 2 to 3 years.

And yet, we also know that within 2 to 3 months of the establishment of a new or expanded rehabilitation or special education program in the community, there will be apparent an increased demand for psychiatric clinic services.

The third area of grave concern is the great lack of programming of treatment services both inpatients and an outpatient day care level, for the severely disturbed, psychotic, and autistic child. These youngsters, the most profoundly disturbed of all children, whose illness begins within the first 2 years of life, would be completely unable to avail themselves of any rehabilitation or special educational services because of the profundity of their illness.

In attempting to help these children, we are faced with shortages on all sides; practically no personnel trained to deal with them in any capacity, practically no places where they can be treated, and very little knowledge with which to attempt to help them.

And yet, they require a tremendous amount of help in order to make it possible to even approach them in the most limited and tentative way with a program of special education in a special setting.

Only a crash program of research into both cause and treatment can be expected to yield results in the next few years which would make it possible for them to be participants in the projected programs of rehabilitation and special education.

I should like to conclude with one final area of major concern which is that there may be a tendency though special legislation to perpetuate the pattern of individual programs for individual groups.

Certainly one of the basic tenets of rehabilitation or of special education is that it is for the person and not for a particular disease or disability.

Already in many communities we are seeing a healthy tendency to merge services, strengthen them through cooperation and coordination, and in brief, focus on the individual rather than on the specific handicap.

In addition to the medical and psychological advisability of such an approach, we cannot overlook the economics involved. In the face of extreme shortages, the pooling of skilled personnel and the elimination of administrative and supervisory multiplication is an additional bonus for such an approach.

In view of the above trends, any legislation for special groups or special purposes must be very carefully designed so as to promote this development toward a total field of rehabilitation.

While it may be true that certain special areas in the fields of rehabilitation and special education need strengthening more than others, their greatest source of strength lies ultimately in their ability to become integrated into the total field and a part of its daily practice.

In conclusion I would like to express my thanks for the opportunity to be here today, and for the interest you have shown.

Mr. GIAIMO. Thank you.

Are there any questions?

Mr. WAINRIGHT. Mr. Chairman, I would like to say that Dr. Smolen has made a very constructive statement. Most witnesses in the very brief time that they are before us do not make the concrete proposals you do in these specifics. That is particularly true of us who are politicians.

I have been on this committee for 8 years and it is with regret that we do not have more time to pursue questions.

You started your remarks, I believe, by saying you were a citizen and a taxpayer as well as a specialist. In regard to your opening remarks then and going to your point 1, which is found at the bottom of page 2 of your testimony, you refer there to the fact that the Office of Education ought to direct aid toward curriculum and teacher training and come up with specific recommendations.

I wonder whether you are not suggesting that the Federal Government get into a field that heretofore it has never been in, particularly with regard to curriculum and teacher training because if you apply it to this and then you carry it to its logical steps in other fields, you find that the Federal Government is making specific recommendations to teacher training and curriculum and fields of history, philosophy, religion, once you go into a field of education which in essence is what your recommendation comes down to.

I wonder if you would care to comment on that.

Mr. SMOLEN. I think this is a very important point.

Yet it seems to me if this is a national problem it requires a national agency to coordinate efforts to alleviate it.

Mr. WAINRIGHT. Of course, all education is a national problem.

Mr. SMOLEN. Is it not quite possible, perhaps, that through the Office of Education an interstate committee might be organized which could accomplish the same purpose and yet avoid the onus of bearing the Federal seal upon its practice?

Mr. WAINRIGHT. Do you know of any other organizations that might be doing this in a research capacity, such as the Ford Foundation, or the Carnegie Fund, or something of the sort that might have a special project or would conduct a special project in this field.

Mr. SMOLEN. I am afraid I cannot speak specifically to exact items. There have been a number of studies and research programs with relatively small groups of teachers developing within these programs a greater sensitivity and awareness of children's problems and disabilities.

Our own clinic has had some such projects, a number of others in the State and throughout the country.

Again we run into a situation where the most part these become demonstration projects and once funds for the demonstration aspect have expired, then it becomes relatively impossible to continue them in any kind of permanent service basis.

Mr. WAINRIGHT. It is too bad, Mr. Chairman, we do not have more time for a complete witness.

Mr. GLAIMO. Thank you, Dr. Smolen.

The next witness is Dr. Francis Irons, director of vocational rehabilitation, Department of Education, Montpelier, Vt.

STATEMENT OF FRANCIS S. IRONS, DIRECTOR, VOCATIONAL REHABILITATION DIVISION, DEPARTMENT OF EDUCATION, MONTPELIER, VT.

Mr. IRONS. Mr. Chairman and members of the Subcommittee on Special Education and Rehabilitation, may I first also commend very highly this procedure you have adopted to get at the grassroots thinking on subjects under consideration.

The Vermont Vocational Rehabilitation Division has been operating for nearly 4 years a halfway house program for the hospitalized mentally ill in close cooperation with the State hospital.

We believe it has been highly successful.

I wish to emphasize three points which I think constitute needs and these have been presented to some extent in the workshop reports. or will be.

There should be real inducement offered in the field of mental hospital construction to promote the development of any hospital rehabilitation facilities and programs. The building of more custodial care units while neglecting rehabilitation services is to perpetuate an obsolete approach to our No. 1 handicapping disease of mental illness.

Another item which our experience in this field is just now pointing out is the need for careful followup of the ex-mental hospital patient on both the service and research phases.

My colleague, the chief psychologist from the State hospital, who has been here for the workshop, says return to hospital peak at 3 months.

Adequate supporting funds from Federal sources to extend follow-up research in the area of rehabilitation of the mentally ill should be of great national benefit in this new field.

Third, we found in our halfway house program the large percentage of the hospitalized mentally ill had lost all family and community ties and support. Those who had been in hospitals in 5 to 20 years, and the average was over 5 years for most of the initial groups, had no economic backing in the community to which they would return. They were literally destitute, as the earning power was restored and they were still making social adjustments we arranged to permit these halfway house clients to accumulate a modest amount of liquid assets in the form of savings accounts at the same time they began to pay part of the costs of their board and room in the halfway house facility.

This accumulation of a reserve we found was a great incentive to those still in the hospital, and it helped provide that feeling of security which leads to complete independence in the community.

However, the Federal auditors caught up with us. They said that the rehabilitation account, Public Law 565, requires that earnings while in the rehabilitation process must be applied in full to the current cost of the individual's rehabilitation program.

Now, in determining the applicant's eligibility in general for financial assistance in applying the means test, Public Law 565 permits that the State plan for vocational rehabilitation exclude as available resource a modest amount in liquid assets in order to provide a reasonable degree of economic stability and a reserve for unexpected emergencies.

We strongly believe that rehabilitation clients who earn during the rehabilitation process should have the same degree of stability and reserve for emergencies.

Therefore, we would recommend that Public Law 565 be amended to permit vocational rehabilitation clients who as applicants were devoid of such assets, but who, while in the active process of rehabilitation become earners, to accumulate from their earnings liquid assets equal to the amount which the approved State plan would have permitted them to exclude as available resource before their rehabilitation program began.

Another one of our concerns is the public acceptance of persons recovered from mental illness, or who are otherwise mentally handicapped, such as the retarded. They need fair opportunity in finding employment.

May I state very briefly a need of considerable importance, then, the name of the President's Committee on the Employment of the Physically Handicapped should be changed by deleting the word "physically." While it remains in the title it implies that this committee does not have sufficient confidence in the employability of those who have mental handicaps to give them their backing.

I would like to emphatically endorse what Congressman Fogarty said about the need for services to help individuals who are not capable of achieving complete vocational independence to become as much interested as they can and, therefore, not have to remain in nursing homes, hospitals, and institutions.

However, it may appear if rehabilitation people themselves through modesty do not speak up in regard to where this program of independent living services should be administered, that it will go by default.

Rehabilitation agencies operate in a philosophy of independence rather than dependence; over the years they have acquired the experience and know-how to provide this kind of service effectively and make these individuals reasonably independent.

Also, these are the agencies which, if in the process of rehabilitation for independent living greater feasibility for vocational success is demonstrated, the rehabilitation agencies are the ones who would carry out the balance of the vocational preparation.

Therefore, I would like to emphasize that these services should be provided in the States by the presently constituted vocational rehabilitation agencies.

One additional point: I would like to second Mayor Lee's statement in regard to sheltered workshops.

Large metropolitan areas in large cities have over the years been able to have this kind of facility. The sheltered workshop is one of the most down-to-earth and practical facilities for returning severely handicapped people to employment, particularly mentally ill and mentally retarded.

But rural areas have not been able to develop these facilities. I think Federal assistance to help rural areas develop sheltered workshops is of great importance.

I thank you very much for the privilege of appearing before you.

MR. GIALMO. We thank the gentleman for coming down from Vermont.

Are there any questions from members of the committee?

Thank you very much.

The next witness will be George T. Pratt, Clarke School for Deaf, Northampton, Mass.

STATEMENT OF GEORGE T. PRATT, PRINCIPAL, CLARKE SCHOOL FOR DEAF, NORTHAMPTON, MASS.

MR. PRATT. Mr. Elliott and members of the committee, thank you for your invitation to me to offer testimony with regard to House Joint Resolution 494, introduced by Mr. Elliott, and its companion resolutions, 488, 503, 507, 512, 516, and 526, presently under consideration by your committee.

I strongly support the resolution and urge an early and favorable recommendation by your committee.

This is the position taken by the Conference of Executives of American Schools for the Deaf, the Alexander Graham Bell Association for the Deaf, and the Convention of American Instructors of the Deaf, which are the three national organizations representing our profession across the country.

The formal education of a deaf child is a highly specialized field and a particularly difficult one. Coming to us without the ability to speak, to understand speech, to read, or to write, he requires special education procedures which are designed to help him compensate for

his hearing loss. He must achieve facility with language, in both its receptive and expressive forms, if he is to fulfill his potential as a human being.

The odds against him seemed to be such that for 210 years following the settlement of Jamestown there was no organized educational program for him in this country.

From the establishment of the American school in 1817 until the present, great strides have been made on behalf of the deaf. There are now 365 schools and classes for deaf children in the United States serving some 30,000 students.

Mr. ELLIOTT. Did I understand you to say there are 300 schools and classes?

Mr. PRATT. Yes.

Mr. ELLIOTT. Does that include classes in public schools?

Mr. PRATT. Yes, sir. A school for the deaf would be a facility which has a program only for deaf children. A class for the deaf would be a classroom within a public school, administered by the public school system, but having one or more classes to take care of deaf children within the public school system.

Mr. ELLIOTT. I thought there were more than that?

Mr. PRATT. There are 365 according to the 1959 American Annals of the Deaf.

There are approximately 4,000 teachers of the deaf.

Now, not one of us is satisfied with our present accomplishments, educationally or administratively, and we are anxious to progress.

Love, affection, and compassion make life more agreeable for the deaf child, but these alone are not enough to open up the doors of opportunity and fulfillment. The professional knowledge and skill of specially trained classroom teachers of the deaf is essential.

What are some of the areas in which classroom teachers of the deaf require special training:

1. Speech: How to teach a deaf child to produce speech which is intelligible to his hearing contemporaries when he can hear neither the speech of others to imitate, nor his own efforts to speak.

2. Language: How to teach a deaf child the flow of connected language including word sequence of accepted usage, tense, agreement of subject and verb, pronouns, et cetera, ad infinitum, when he does not hear the spoken word.

Consider the struggle of hearing children with spoken and written language even though they are constantly exposed to it from birth.

3. Curriculum: How to organize and present learning experiences and subject matter to deaf children that they might acquire the basic fundamentals which will enable them to learn and explore independently.

4. Auditory training: How to exploit the residual hearing which most deaf children possess through modern amplification equipment. In addition to assisting with lipreading, this helps in contending with the feeling of "aloneness" peculiar to deafness, and contributes toward a sense of being a part of the world, as well as being in it.

5. Psychology: How does the lack of hearing experience affect the thinking, responses, and attitude of deaf children and adults?

6. Observation and practice teaching: Daily contact with deaf children in well-graded classes over an extended period of time under the guidance and supervision of experienced teachers is necessary in training teachers of the deaf.

There are other special courses which teachers in training must take to meet minimum certification requirements recognized by our profession. At least 1 full academic year of special training is necessary to prepare one's self to teach deaf children.

For the record, I offer this little pamphlet containing information on the 25 training centers. I will not read it.

MR. GIALMO. It will be made a part of the statement and put in the record, without objection.

MR. PRATT. Thank you, sir.

(The pamphlet referred to follows:)

[Pamphlet submitted by George T. Pratt, Clarke School for Deaf]

INFORMATION FOR PROSPECTIVE TEACHERS OF THE DEAF

(For schools for the deaf, classes for the deaf, speech and hearing clinics, and rehabilitation facilities for the deaf in the United States and Canada)

A STIMULATING PROFESSION

One of the most rewarding areas in specialized education is that of teaching the deaf. Although this area is in the general field of education, it is closely allied with the fields of medicine, psychology, speech, language disorders, electronics, rehabilitation, audiology, public health, and social work. The work is of such a specialized nature that additional training is necessary.

The need for teachers in this particular area of special education is acute. A scarcity of qualified personnel exists throughout the United States and Canada. Positions are available in public and private residential schools, day schools, and in day classes.

Trained teachers of the deaf are also needed in many speech and hearing clinics located in colleges and universities, schools for the deaf, private centers, hospitals, and in medical schools.

Scholarships are available for teacher trainees in the majority of the training centers. Interested applicants should write to the directors of the teacher training centers for details and refer to information on scholarships at the various centers in this brochure.

Information concerning the 25 teacher training centers meeting standards approved by the Conference of Executives of American Schools for the Deaf and the courses necessary for a teacher's certificate are included in this brochure. Training is offered in various centers on the graduate and the undergraduate levels.

TEACHER TRAINING CENTERS

Centers meeting the standards approved by the Conference of Executives of American Schools for the Deaf granting college degrees or college hours of credit, January, American Annals of the Deaf, 1959

Name and location of teacher training center	Telephone No.	Date of founding	Name of director of teacher training center	University or college affiliation	Practice teaching centers	Grade span in practice school
Arkansas: School for the Deaf, Little Rock, Ark. California: San Francisco State College, 124 Buchanan St., San Francisco.	FR 2-0236 JU 4-2300	1952 1948	Roy G. Parks, M.A. William Urdane, Ph. D.	University of Arkansas San Francisco State College.	Arkansas School for the Deaf. Gough School, San Francisco. Roosevelt School, Burlingame; School at Berkeley. John; Tracy Clinic, Hyde Park Day School. Mary E. Bennett, Los Angeles. California School for the Deaf, Riverside. Kendall School, Maryland School, Western Pennsylvania School, West Virginia School. Iowa School for the Deaf.	Preschool and 11 grades. Preschool, grades 1-6. Advanced grades available. Preschool and grades 1-6. Nursery and grades 1-6. Preschool and grades 1-12. Preschool to grade 12.
John Tracy Clinic, 806 West Adams St., Los Angeles. Los Angeles State College of Applied Arts and Sciences.	RI 8-5481 CA 5-5621	1951 1949	Edgar L. Lowell, Ph. D., Marguerite Stoner, M.A. Francis E. Lord, Ph. D., Patricia Stafford, M.A.	University of Southern California. Los Angeles State College of Applied Arts and Sciences.		
District of Columbia: Graduate Department of Education, Gallaudet College, Washington, D.C.	LI 7-7200	1891	Frances I. Phillips, M. Ed.	Gallaudet College.		
Iowa: Iowa School for the Deaf, Council Bluffs, Iowa.	5549	1936	C. Joseph Giangreco, M.A., Dip. in Adm.	State University of Iowa, Iowa City, Iowa. University of Omaha.		Preschool, grades 1-12.
Kansas: Kansas School for the Deaf, Olathe; University of Kansas, Medical Center, Kansas City, Kans.	TA 2-5252	1952	Jane Miller, Ed. D.	University of Kansas, Lawrence, Kans.	Kansas School for the Deaf, Olathe, and Preschool for Deaf, Medical Center, Kansas City, Kans. Clarke School.	Preschool, grades 1-9.
Massachusetts: Clarke School for the Deaf, Round Hill Rd., Northampton, Mass.	JU 4-3450	1892	George T. Pratt, M. Ed., L.H.D.	Smith College, University of Massachusetts, Syracuse University.		Preschool, grades 1-8.
Michigan: Horace H. Rackham School of Special Education, Ypsilanti, Mich. Wayne State University, Detroit, Mich.	TE 1-1450	1925 1935	Allen Myers, Ed. D. John J. Lee, Ph. D., John W. Tenney, Ed. D., John Gaeth, Ph. D.	Eastern Michigan State College. Wayne State University	Rackham School and Michigan School for the Deaf. Day School, Detroit, Evangelical Lutheran School.	Preschool, grades 1-6. Preschool, grades 1-9.
Missouri: Central Institute for the Deaf, 818 South Kingshighway, St. Louis. New Jersey: New Jersey School for the Deaf, West Trenton.	OL 2-3200 EX 6-1551	1916 1955	S. Richard Silverman, Ph. D. Charles M. Jochem, M.A.	Washington University Trenton State College, Trenton.	Central Institute New Jersey School for the Deaf.	Preschool, grades 1-8. Nursery, grades 1-12.

New York: Lexington schoolteacher preparation course, 904 Lexington Ave., New York, N.Y.	TR 9-8100.	1906	Clarence D. O'Connor, M.A., L.H.D.	Teachers College, Columbia University.	Lexington School.	Preschool, grades 1-9.
St. Mary's School for the Deaf, and University of Buffalo, 2253 Main St., Buffalo, N.Y.	UN 3810.	1914	Sister Rose Gertrude, Ph. D.	University of Buffalo.	St. Mary's School.	Preschool, grades 1-12.
Syracuse University, Gordon Hoople Speech and Hearing Center, Syracuse.		1947	Louis M. DiCarlo, Ed. D.	Syracuse University.	Syracuse University and Clarke School.	Primary, intermediate, upper.
North Carolina: North Carolina School for the Deaf, Morganton, N.C.	HE 7-1166.	1894	Ben E. Hoffmeyer, M.A.	Appalachian State Teachers College, Boone, N.C. and Lenoir Rhyne College, Hickory, N.C.	North Carolina School for the Deaf.	Preschool, grades 1-12.
Oklahoma: Oklahoma College for Women, Chickasha, Okla.	CA 4-3140.	1953	John A. Morris.	Oklahoma College for Women.	Jane Brooks School for Deaf.	Nursery to 9th grade.
University of Oklahoma School of Medicine, Speech and Hearing Center, 800 East 13th St., Oklahoma City, Okla.	CE 6-1511.	1947	Mrs. Helen Walcher, John W. Keys, Ph. D.	University of Oklahoma, Norman.	School for the deaf in the clinic.	Preschool, grades 1-6.
Pennsylvania: Western Pennsylvania School, Edgewood, Pittsburgh, Pa.	FR 1-7000.	1926	Sam. B. Craig, M.A., Litt. D.	University of Pittsburgh.	Western Pennsylvania School.	Preschool, grades 1-9.
DePaul Institute, Pittsburgh, Pa.		1913	Rev. Thomas R. Bartley, M. Ed.	Duquesne University.	DePaul Institute.	Nursery-9th grade.
South Carolina: Teacher Training Department, South Carolina School for the Deaf, Spartanburg, S.C.	3-4377.	1949	N. F. Walker, M.A.	Converse College.	South Carolina School.	Preparatory I and II, grades 1-10.
South Dakota: Augustana College, Sioux Falls, S. Dak.	4-6381.	1953	Richard W. Flint, M.S.	Augustana College.	South Dakota School for the Deaf.	Preschool, grades 1-12.
Tennessee: Tennessee School for the Deaf, Knoxville.	4-3053.	1938	W. Lloyd-Graunke, Ph. D.	University of Tennessee.	Tennessee School for the Deaf.	Preschool, grades 1-10.
Washington: Washington School for the Deaf, Vancouver.	OX 3-6732.	1950	Virgil W. Epperson, B.A.	Lewis and Clarke College.	Washington State School for the Deaf.	Primary, grades 1-10.
Wisconsin: University of Wisconsin, Milwaukee.	WO 4-4400.	1913	Alice Streng, M.A.	University of Wisconsin, Milwaukee.	Nebraska-Blinner School, Stephen Junior High, Lincoln High School, Atwater School.	Preschool, high school.

¹ For hearing teacher trainees.

Centers meeting the standards approved by the Conference of Executives of American Schools for the Deaf granting college degrees or college hours of credit, January, American Annals of the Deaf, 1959—Continued

Name and location of teacher training center	Present enrollment practice school	Present number of teaching personnel in practice school	Present number of teacher personnel in training school	Total number of pupils graduated from practice teaching school	Total number of teachers graduated from training center	Total trainees finishing in 1959	Degrees granted	Does completion of studies automatically grant trainees a degree?	Requirements	
									Years of college	Hours of education
Arkansas: School for the Deaf, Little Rock, Ark.	243	28	4	3, 184	26	4	B.S. in Ed.	Yes	3	Same as for a major in education.
California: San Francisco State College, 1600 Holloway Ave., San Francisco.	50	11	3	2, 785	35	6	A.B. M.A.	No, 30 hours graduate credit.	4	34.
John Tracy Clinic, 806 West Adams St., Los Angeles.	24	13	8	103	17	1	M.S. Ed.	31 units undergraduate.	1 4	
Los Angeles State College of Applied Arts and Sciences.	137 220	27	3	32 1, 970	60	10	B.S. Ed. A.M. A.B.	No, 38 units graduate credit. Yes, 30 hours undergraduate credit.	2 2	
District of Columbia: Graduate Department of Education, Gallaudet College, Washington, D.C.	1, 376	227	4		416	16	M.S. in Ed. ¹	No, 32 credit hours	4	18 education and psychology.
Iowa: Iowa School for the Deaf, Council Bluffs, Iowa.	312	63	5	4, 555	117	4	A.B. M.S.	No, 28 semester hours	3	
Kansas: Kansas School for the Deaf, Olathe, Kans., University of Kansas Medical Center, Kansas City, Kans.	280	40	8	3, 000	22		M.S.	Yes	4	
Massachusetts: Clarke School for the Deaf, Round Hill Road, Northampton, Mass.	174	38	12	1, 702	566	18	M.A. M.S.	No, 30 hours graduate credit.	4	
Michigan: Horace H. Rackham School of Special Education, Ypsilanti, Mich.	102	5	29			7	M.A. B.S.	Yes	4	20.
Wayne State University, Detroit, Mich.	450	45	6		2	3	B.S., A.B. M. Ed. Ed.D.	Yes		
Missouri: Central Institute for the Deaf, 818 South Kingshighway, St. Louis.	165 1, 800	38	10	2, 610	427	11	A.B. M.S., B.S., M.A.	No, 64 hours credit	2 4	
New Jersey: New Jersey School for the Deaf, West Trenton.	356	43	9	1, 843	11	3	M.A.	No, 22 credit hours	4	

New York: Lexington School Teacher Preparation Course, 904 Lexington Ave., New York N.Y.	238	39	7	524	12	M.A.	Yes, 32 graduate credit hours.	4
St. Mary's School for the Deaf, and Uni- versity of Buffalo, 2253 Main St. Buffalo, N.Y.	300	56	20	2,471	10	M.Ed.	No, 28 hours graduate credit.	4
Syracuse University, Gordon Hoople Speech and Hearing Center, Syracuse.	10	3	16	70	6	B.S.	Yes	2
North Carolina: North Carolina School for the Deaf.	465	75	4	4,906	6	M.S. B.S.	No, 30 hours credit	2
Oklahoma: Oklahoma College for Women, Chickasha, Oklahoma.						B.S.	Yes	
University of Oklahoma, School of Medi- cine, Speech and Hearing Center, 800 East 13 St., Oklahoma City, Okla.	39	6	8	57	5	A.B. M.A.	No, 60 hours	
Pennsylvania: Western Pennsylvania School, Edgewood, Pittsburgh, Pa.	420	46	10	4,686		M.A.	No	4
DePaul Institute, Pittsburgh, Pa.	241	41	10	400		B.S.	No	2
South Carolina: Teacher Training Depart- ment, South Carolina School for the Deaf, Spartanburg, S.C.	151	17	6	1,267	7	M.S. A.B. B.S.	No, 26 semester hours	2
South Dakota: Augustana College, Sioux Falls, S. Dak.	109	16	3	945	3	B.S.	do	
Tennessee: Tennessee School for the Deaf, Knoxville.	407	60	10	3,311	1	A.B. B.S. M.S.	Yes	2 Varies.
Washington: Washington School for the Deaf, Vancouver.	245			1,000		A.B.	No, 32 semester hours	4 Varies.
Wisconsin: University of Wisconsin, Mil- waukee.	150	23	3		6	B.S. M.S.	Yes	
Total: 25 centers					126			

with deaf children. Requirements for graduation: 24 semester hours and completion of a project.

¹ Graduate.

² Undergraduate.

³ It is uncertain whether these 10 students will finish their training in June.

⁴ Also offer a professional diploma. Requirements: a master's degree in education, 1

year of training in the education of the deaf, and at least 3 years of professional experience

NOTE.—Total number of teachers finishing training in the United States in 1959, 126.

MINIMUM COURSE REQUIREMENTS TO BE INCLUDED IN A PROGRAM FOR PREPARATION OF TEACHERS OF THE DEAF IN CENTERS MEETING THE STANDARDS APPROVED BY THE CONFERENCE OF EXECUTIVES OF AMERICAN SCHOOLS FOR THE DEAF¹

I. Following are the minimum course requirements that are to be included in a teacher preparation program for those training centers to be approved by the Conference of Executives of American Schools for the Deaf. Suggested minimum and maximum semester hours of credit are indicated for each course. It is recognized that course content rather than course title is the guide.

	Semester hours	
	Mini- mum	Maxi- mum
A. The teaching of speech to the deaf..... This course should include a study of the principles and techniques used in developing the formation of English sounds by the analytical method and also the introduction of speech by the whole-word method. Some time should be devoted to the correction of speech defects in the hard of hearing, but the major emphasis should be placed on the development of speech in the preschool and school-age deaf child. It is essential that demonstrations and practice with deaf children under expert supervision be an integral part of this course. The course should include special consideration of the speech problems of the deaf child with multiple handicaps.	4	6
B. The teaching of language to the deaf..... This course should include a study of the principles and techniques of teaching language to the preschool and school-age deaf child. The student should become familiar with the leading systems of teaching language to the deaf and should become familiar with the step-by-step development of at least 1 language system. The material in "Outline of Language for Deaf Children," by Edith M. Buell or the "Language Outline," prepared by a committee of teachers at the Central Institute for the Deaf or similar material should form the basis of this course. The course should include consideration of the language problems of deaf children with multiple handicaps.	4	6
C. Methods of teaching elementary school subjects to the deaf..... This course should include principles and methods of teaching reading to deaf children in the lower and higher grades. Methods of teaching subjects such as arithmetic, social studies, and science should be considered in this course. Particular emphasis should be placed on methodology in the intermediate and advanced grades. This course should also include consideration and use of visual aids in classes for the deaf.	4	6
D. Methods of teaching speech reading (lipreading) to the deaf and the hard of hearing..... The various principles and techniques of teaching speech reading should be studied. Familiarity with such methods as the Nitchie, Jena, Kinzie, Müller-Walle and others, and research pertaining to lipreading should be a part of this course.	2	3
E. History, education, and guidance of the deaf..... This course should cover the history of the education of the deaf and the evaluation of the place of the deaf in the community from social, economic, and political viewpoints from ancient times to the present. The course should help the student become familiar with the bibliographic source materials in the field on the education and welfare of the deaf. Research studies related to the psychology of the deaf, social adjustment of the deaf, and studies related to the learning problems of the deaf should be considered. The student should become familiar with the place of the adult deaf in today's society.	2	3
F. Auditory and speech mechanisms..... This course should include a study of the anatomy, physiology, and pathology of the speech and hearing mechanisms.	2	3
G. Hearing tests and auditory training..... The techniques and interpretation of pure tone hearing tests and an introduction to speech audiometry should be included in this course. Audiogram interpretation and at least 10 air and bone conduction tests should be completed on children of varying ages who are in schools or classes for the deaf. The students should be introduced to several types of amplification systems used in schools and classes for the deaf. In auditory training, the student should learn the techniques and principles of auditory training with special reference to such programs in schools and classes for the deaf.	2	3
H. Observation and student teaching..... Facilities for observation of classroom procedures and student teaching should be sufficiently extensive so that the deaf pupils are well graded. This implies at least 6 classes at different grade levels, including preschool if possible. The student should be required to do at least some practice teaching under direct supervision on several grade levels, in order that he might have an understanding of the overall educational problems of the deaf child.	6	10
Total semester hours.....	26	40

¹ The revised set of requirements was adopted at the meeting of the Conference of Executives of American Schools for the Deaf in Colorado Springs, Colo., June 30 and July 1, 1959.

II. (1) The above minimum course requirements presuppose that the student has had work in the area of education, preferably a major in elementary education. The student should have had, or should be taking concurrently, a course in child growth and development, and a course in the psychology or education of the exceptional child.

(2) Upon request, training centers established in the future will be evaluated by a subcommittee of one or more members of the conference of executives appointed by the chairman of the teacher training and certification committee. The criteria listed in section I will be used for evaluation of new training centers until such time as these requirements are changed by majority vote of the members of the conference of executives.

REVISION OF REQUIREMENTS FOR CLASS A AND CLASS B CERTIFICATION

CONFERENCE OF EXECUTIVES OF AMERICAN SCHOOLS FOR THE DEAF²

Class A—Academic

To be eligible for this certificate the following three requirements must be met:

1. All candidates for a class A certificate must hold at least a bachelor's degree from an accredited college or university.

2. All candidates for a class A certificate must have satisfactorily completed a program of preparation as a teacher of the deaf at a training center which has been evaluated and approved by the Conference of Executives of American Schools for the Deaf. Deaf graduates of Gallaudet College who major in education will meet this requirement.

3. Following the preparation, 3 years of successful teaching experience under qualified supervision is required for a permanent certificate. A temporary certificate may be granted following preparation and before the necessary experience is completed.

In lieu of the above requirements, this class A certificate may be granted when, in the judgment of the certification committee, applicants have qualified through executive or administrative positions or distinguished service in education of the deaf.

Class B—Academic

To be eligible for this certificate the following two requirements must be met:

1. All candidates for a class B certificate must hold at least a bachelor's degree from an accredited college or university.

2. (a) Completion of 24 semester hours in the education of the deaf, such courses being subject to the approval of the teacher training and certification committee of the conference of executives, and the 3 years of teaching experience with deaf children; or

(b) Completion of 8 years of satisfactory teaching experience with deaf children, attested to by a supervisor or administrator of a school for the deaf.

These requirements are to become effective September 1, 1959. Applicants for certification who completed their preparation to teach the deaf before this date will be evaluated on the basis of requirements previously in effect.

Directors of training centers making application for evaluation and approval of a teacher education program should write to Dr. Howard M. Quigley, chairman of the Teacher Training and Certification Committee, Conference of Executives of American Schools for the Deaf, Minnesota School for the Deaf, Fairbault, Minn.

Teachers of the deaf making application for certification should write to Dr. Richard G. Brill, secretary of the Teacher Training and Certification Committee, Conference of Executives of American Schools for the Deaf, California School for the Deaf, Riverside, Calif.

² The revised set of requirements was adopted at the meeting of the Conference of Executives of American Schools for the Deaf in Colorado Springs, Colo., June 30 and July 1, 1959.

INFORMATION ON SCHOLARSHIPS, FELLOWSHIPS, AND STIPENDS IN TEACHER
TRAINING CENTERS FOR THE DEAF

ARKANSAS SCHOOL FOR THE DEAF, LITTLE ROCK, ARK.

Room, board, and laundry, free of charge.

Tuition is reduced by the University of Arkansas to \$50 per semester.

SAN FRANCISCO STATE COLLEGE, CALIFORNIA

Several cash scholarships ranging from \$1,000 to \$1,500 are awarded annually. These are granted with the understanding that the students complete the program for certification during the following year and are subject to an agreement to teach deaf children for at least 2 years following completion of preparation. Application must be made before March 1. Forms for application become available after the first of January. For further information address director of admissions, San Francisco State College, 1600 Holloway Avenue, San Francisco, Calif.

JOHN TRACY CLINIC, LOS ANGELES, CALIF.

A number of tuition scholarships of \$900 each are available to senior undergraduate students or candidates for the master's degree. These include two Disney Foundation scholarships, the Westlake Alumnae scholarship, and several from anonymous donors.

The scholarships are granted jointly by the John Tracy Clinic and the University of Southern California. For further information regarding financial aid write to the administrator, John Tracy Clinic, 806 West Adams Boulevard, Los Angeles, Calif., and to the director of admissions, University of Southern California, Los Angeles, Calif.

GALLAUDET COLLEGE, WASHINGTON, D.C.

Financial assistance: Students in the regular session receive free tuition and maintenance. Those in need of further assistance may apply for a national defense student loan in any amount up to \$1,000 or for the Kiwanis scholarship of \$500. For further information, including application forms for admission, write to the registrar, Gallaudet College, Washington, D.C.

IOWA SCHOOL FOR THE DEAF, COUNCIL BLUFFS, IOWA

The in-service teacher-training program of the Iowa School for the Deaf is affiliated with both the University of Iowa and the University of Omaha, and is approved by the Conference of Executives of American Schools for the Deaf.

In this unique program, teachers with baccalaureate degrees are hired at full salary, as teachers of the deaf, with the understanding that they take the complete teacher-training program. Working closely with supervising teachers, these teachers-in-training carry a full teaching load and take classes in education for the deaf after school hours on the campus of the Iowa School for the Deaf.

For further information, write to the superintendent, Iowa School for the Deaf, Council Bluffs, Iowa.

THE UNIVERSITY OF KANSAS MEDICAL CENTER, KANSAS CITY, KANS., AND
THE KANSAS SCHOOL FOR THE DEAF, OLATHE, KANS.

The University of Kansas Medical Center, in cooperation with the Kansas School for the Deaf, has the following financial aid available to students:

1. A student may receive room, board, and laundry at the school in exchange for a few hours of work a week with the children and/or

2. Stipends ranging from \$300 to \$750 for the year. Transportation is provided between the School for the Deaf in Olathe and the University of Kansas Medical Center in Kansas City, Kans., for those who live at the school.

Fees and tuition payable by out-of-State students amount to approximately \$260. For further information write to Dr. June Miller, University of Kansas Medical Center, 39th and Rainbow, Kansas City, Kans., and/or Stanley D. Roth, superintendent, Kansas School for the Deaf, Olathe, Kans.

THE CLARKE SCHOOL FOR THE DEAF, NORTHAMPTON, MASS.

The fees for the school year are as follows: tuition, \$1,200; room and board, \$600. Clarke School awards a full tuition scholarship to each student admitted in the teacher education department. Some scholarship aid in the form of minor duty assignments which will not interfere with studies, to be applied against the \$600 fee for room and board is available. For further information write to Dr. George T. Pratt, principal, the Clarke School for the Deaf, Northampton, Mass.

WAYNE STATE UNIVERSITY, DETROIT, MICH.

Wayne State University has an unlimited number of tuition scholarships (\$100 up to \$500) for Michigan residents preparing initially to teach the deaf; three or four graduate assistantships paying approximately \$2,000 with some tuition waivers at the master's level; and four research associate fellowships paying up to \$3,000 with some tuition waivers at the doctoral level. For further information write to Dr. John Gaeth, professor of audiology, Speech and Hearing Clinic, Wayne State University, 656 West Warren, Detroit, Mich.

EASTERN MICHIGAN UNIVERSITY, YPSILANTI, MICH.

Horace H. Rackham School of Special Education

Eastern Michigan University students who are pursuing a program in the area of the acoustically handicapped are eligible for many scholarships and grants-in-aid.

Six annual \$150 scholarships are sponsored by the Dearborn Lions Club. Other students who show need and agree to teach in Michigan for a period of time, are eligible for scholarships from the Michigan Society for Crippled Children and Adults. Students in the area of the acoustically handicapped are also eligible for one of the many (approximately 525) State board scholarships. Many other students get assistance through the loans provided by the National Defense Education Act of 1958. The Rackham dormitory provides jobs for approximately 20 to 25 students per year. Graduate students are eligible for student assistantships at the Rackham School.

For further information contact Dr. Allen Myers, director, Rackham School of Special Education, Eastern Michigan University, Ypsilanti, Mich.

CENTRAL INSTITUTE FOR THE DEAF, ST. LOUIS, MO.

A matriculation fee of \$5 is required upon registration.

Tuition for each year is \$300, payable as follows: \$25 initial payment upon acceptance for admission, \$125 at opening of first semester and \$150 at the beginning of each subsequent semester.

A diploma fee of \$3 is payable prior to graduation.

Room and board are available to college students at the rate of \$660 per academic year, payable monthly in advance. Students are not accepted for room or board separately. Commitment must be made for both services.

A laboratory fee of \$10 is payable in those graduate courses requiring the use of animal material.

An outlay of \$100 for books and supplies is sufficient to carry the student for the entire course.

An annual health service fee of \$2 is required in advance.

Scholarships and self-help

The Max A. Goldstein scholarship.—This scholarship is derived from annual contributions of the alumni of the teachers training college and provides tuition fees for 1 year. Award is made to a student usually in the senior year, upon recommendation of the college faculty. Other scholarships and some grants-in-aid are available to qualified students.

Opportunities for self-help through remunerative employment on the premises of the institute are available. This employment usually consists of counseling with the children after school hours, study hall, and clerical duties. Students are also permitted to sign promissory notes to meet tuition obligations.

Application for scholarships, employment, and loans should be addressed to the Registrar, Central Institute for the Deaf, 818 South Kingshighway, St. Louis, Mo.

THE LEXINGTON SCHOOL, NEW YORK, N.Y.

The Lexington School teacher preparation program is affiliated with Teachers College, Columbia University, and provides the basic program for the preparation of teachers of the deaf in the department of special education.

The Lexington School has a program of scholarship assistance for those candidates who indicate need for such help. Application for such scholarship grants must be made in writing. Resident scholarships have a value of \$1,200 and provide board, room, and laundry at the Lexington School for the academic year, and \$200 in cash. Nonresident scholarships provide \$200 in cash and lunch and dinner at the school on school days. One-half of the cash scholarships will be paid in September, the other half in January. In addition, under certain conditions, those members of the teacher preparation department who need financial assistance during the year in order to complete their program may apply to the Lexington School for non-interest-bearing loans up to \$500. Half of this amount may be borrowed in the first semester, the other half in the second semester. These loans may be repaid after the student-teacher secures employment. Under certain conditions, fellowships, scholarships, or loans may be secured from Teachers College, Columbia University. Inquiries concerning these should be addressed to the chairman of the Committee on Fellowships and Scholarships of Teachers College prior to December 15 preceding the academic year for which the student-teacher is appointed.

ST. MARY'S SCHOOL FOR THE DEAF, BUFFALO, N.Y.

St. Mary's School offers 10 assistant-teacher positions each year, at a salary of \$1,800. The student-teacher helps in the coaching of individual pupils assists in preschool and other classes, acts as substitute teacher, etc. The training classes are usually held either before or after school hours.

For further information write to the Director, teacher training program, St. Mary's School for the Deaf, Buffalo, N.Y.

SYRACUSE UNIVERSITY, SYRACUSE, N.Y.

No scholarships available.

NEW JERSEY SCHOOL FOR THE DEAF

The teacher-training program is a combined in-service and graduate program. The trainees are first- and second-year classroom teachers receiving beginning salaries.

The program is affiliated with Trenton State College. Twenty-two hours credit in special education courses pertaining to the deaf are required. A student may earn a master's degree with 10 additional hours credit.

The tuition is \$13.50 per point.

For further information write to Mr. C. M. Jochem, superintendent, New Jersey School for the Deaf, West Trenton, N.J.

NORTH CAROLINA SCHOOL FOR THE DEAF, MORGANTON, N.C.

The North Carolina School for the Deaf has six working scholarships for teachers in training. A trainee receives \$82.50 per month for 10 months. For this amount the trainee fills part-time positions in the library, school offices, and as assistant in physical education and as substitute houseparent. From the amount received, the trainee must pay \$50 per month for room, board, and laundry, and \$250 per year to the North Carolina School for the Deaf and the affiliating college for tuition.

The scholarships granted at the North Carolina School for the Deaf are designed to encourage desirable candidates by affording them training at no cost to them, other than their part-time services to the school.

The positions are designed to give the trainee contact with the deaf student in and out of school, so that the trainee can acquire a better understanding of the deaf child.

For further information write to Ben E. Hoffmeyer, superintendent, North Carolina School for the Deaf, Morganton, N.C.

THE UNIVERSITY OF OKLAHOMA MEDICAL CENTER, OKLAHOMA CITY, OKLA.

Graduate assistantships, research assistantships, and office of vocational rehabilitation assistantships are available for those studying in audiology, speech pathology, or in the teaching of the deaf. For further information write to Dr. John W. Keys, 825 NE. 14th Street, Oklahoma City, Okla. Scholarships run from \$1,320 to \$2,800 a year.

OKLAHOMA COLLEGE FOR WOMEN, CHICKASHA, OKLA.

Scholarships granted by the American Business Clubs are available to junior and senior students. Applicants for scholarships should apply through local American Business Clubs or to Robert Park, chairman, National Committee on Scholarships, Federal Savings & Loan Building, Chickasha, Okla. Scholarships may cover tuition, room, and board, and cost of books.

THE WESTERN PENNSYLVANIA SCHOOL FOR THE DEAF, PITTSBURGH, PA.

For scholarship arrangements write to Superintendent Sam B. Craig, 300 Swissvale Avenue, Pittsburgh 28, Pa.

THE DE PAUL INSTITUTE FOR THE DEAF, PITTSBURGH, PA.

The teacher training program was designed primarily to supply DePaul's need for qualified oral teachers. Others are accepted when openings in the program are available.

Applicants should have a bachelor's degree from an accredited college or university, and a State teacher's certificate. The course is of 2 years' duration.

Tuition scholarships, room, and board are available for qualified applicants.

For further information write to the director, the DePaul Institute, Castle-gate Avenue, Pittsburgh, Pa.

SOUTH CAROLINA SCHOOL FOR THE DEAF, SPARTANBURG, S.C.

The teacher-training program offered by the South Carolina School for the Deaf in cooperation with Converse College, is a 2-year undergraduate course carrying 26 hours of college credit. The course is open to juniors and seniors who have the approval of the dean of faculty at Converse College and of the assistant superintendent of the school for the deaf.

For further information write to Mr. N. F. Walker, assistant superintendent, South Carolina School for the Deaf and the Blind, Spartanburg, S.C.

SOUTH DAKOTA SCHOOL FOR THE DEAF, AUGUSTANA COLLEGE, SIOUX FALLS, S. DAK.

A variety of scholarships for freshmen, and upper classmen are available, on a competitive basis, upon application. In general, to be eligible for an Augustana scholarship, the student applicant must present an academic record of unusual quality, show promise of achievement and aptitude for college work, have good character and a record of leadership in school, church, and community life, and demonstrate financial need.

All scholarships, grants-in-aid, assistantships, part-time jobs, loans, and similar types of financial aid to students are administered by a faculty committee on student aid. In addition to the above types of college aid, there are several student assistantships for board and room available from the South Dakota School for the Deaf, for students who assist in their program.

For further information write to Augustana College or Prof. Richard W. Flint, director, education program for teachers of the deaf, Augustana College.

TENNESSEE SCHOOL FOR THE DEAF, KNOXVILLE, TENN.

The superintendents of the special schools under the administration of the State board of education are authorized to allow grants-in-aid for graduate study to selected faculty members, subject to individual approval by the State board of education and to the conditions set forth below:

(1) Any professional staff member of the special schools under the control of the State board of education now employed, or who may be employed in the future, shall be eligible to apply for a grant-in-aid for study in the field of specialization required by the school.

(2) No grant-in-aid shall be made to a faculty member to do graduate work toward a doctorate or a master's degree in a field other than the field of specialization in which he is now working at the institution, but the field of specialization in which he will be employed upon his return to the institution.

(3) The recipient of a grant-in-aid shall agree to remain as an employee of the institution making the grant for a period of time equal to twice the time for which he received a grant-in-aid from the institution, but under no circumstances will a grant-in-aid be made unless the recipient agrees to remain with the institution for 1 full year after the completion of his graduate work. Failure of the recipient to remain for the period of the agreement will result in the repayment of the amount granted the recipient according to the terms of his contract, with interest at 6 percent.

(4) Full grants-in-aid may be made for a subsistence and maintenance stipend only for a faculty member who is planning three continuous quarters or two continuous semesters of graduate work on the doctoral level or beyond a master's degree. A grant of tuition, plus one-half subsistence, may be allowed for summer school attendance.

(5) The amount of the individual grant-in-aid will depend on the needs and circumstances of the individual.

For further information write to W. Lloyd Graunke, Ph. D., chairman, superintendent, Tennessee School for the Deaf.

WASHINGTON STATE SCHOOL FOR THE DEAF, VANCOUVER

The training center at the Washington State School for the Deaf offers complete teacher training, recognized by the Conference of Executives of American Schools for the Deaf, with accreditation by Lewis and Clark College of Portland, Oreg. Upon completion of the 9-month course on the State school campus in Vancouver, under certified educators in the teacher training area, the trainee is allowed 32 semester hours undergraduate credit or up to 16 hours graduate credit. No charge is made to the trainee for training school facilities, materials, and supplies. The trainee pays one single fee, a reasonable tuition fee, set by the college.

THE UNIVERSITY OF WISCONSIN: MILWAUKEE, MILWAUKEE, WIS.

University freshman honor scholarships for Wisconsin residents are awarded to the top-ranking students in each graduating class upon recommendation of the high school principal.

University freshman tuition and cash scholarships for Wisconsin residents are available upon application. Need and academic record are qualifying considerations.

Continuing students, including nonresidents, are eligible for university scholarships, both cash and tuition, upon application.

The Winnie Memorial Award of \$50 is available to senior students majoring in the education of the deaf. An occasional scholarship of \$100 is presented by the American Business Women's Association.

For further information, write to Miss Alice Streng, chairman, department of exceptional education, the University of Wisconsin: Milwaukee, Milwaukee, Wis.

Mr. PRATT. There is an acute nationwide shortage of trained classroom teachers of the deaf. This has been substantiated by a study conducted this year by Johnston & Frisiana, the facts and conclusions of which will be introduced into this hearing by Mr. Fred D. Knittle, who has been designated by the Conference on Executives of American Schools for the Deaf, to speak for that organization.

Over the past 10 years I have attended many of our professional meetings and heard papers and panels given at each directed to the problem of the teacher shortage. The net tangible result seems to have been a steady worsening of the situation.

A basic problem of finances is involved. After students have completed 12 years of elementary and high school, then committed their families to the expense of college or university, it is natural for them

to want financial independence and to proceed at once to accept employment.

Many college students may have an active interest in preparing themselves to teach deaf children, but feel they cannot ask their parents to support them financially during the training period required. Thus, our profession loses teachers and future leaders.

This national shortage of classroom teachers of the deaf began during World War II and has persisted until today, becoming more acute year by year. Its effects are detrimental no matter how schools for the deaf may have attempted to accommodate themselves to it:

1. By admitting fewer children;
2. By enlarging the number of children in classes;
3. By employing untrained teachers and attempting an "in-service" training program.

The limited numbers of students flowing into our training centers has persisted so long that our profession now faces further significant difficulties which are directly associated with the basic shortage.

Schools are not able to find supervising teachers, principals, or superintendents to administer educational programs.

During the past 5 years we have received letter after letter asking us to recommend persons for highly responsible and well paid positions, but good people are already holding positions of leadership and do not wish to change.

Directors of our research departments have not been able to develop enough young scientists who are interested directly in our special field to mount a truly substantial research effort. Even though the many ramifications of deafness present the most stimulating and challenging possibilities, research grants to our special field have been meager: It is becoming increasingly difficult to staff the training centers themselves.

The problem we are outlining here lies at the heart of our profession, and the situation is critical.

If the provisions of this resolution were to go into effect immediately, it would take us 10 years at least to catch up.

We urge you, with all sincerity, to place House Joint Resolution 494 high on your agenda for consideration when Congress reconvenes in January. Early favorable action will make it possible for us to try to fill our training centers with students for the school year beginning in September 1960. Recruiting reaches its peak in February and March.

Thank you very much.

MR. GIALMO. Are there any questions by the members of the committee?

We thank you at this time, Mr. Pratt, for your testimony today.

The next witness is Mrs. Albert M. Grass, president of the American Epilepsy Foundation, Quincy, Mass.

STATEMENT OF MRS. ALBERT M. GRASS, PRESIDENT, AMERICAN EPILEPSY FOUNDATION, QUINCY, MASS.

MRS. GRASS. I want to speak to you briefly about the educational needs of the epileptic child emphasizing that these are not specific to New England or indeed, to the United States, but a worldwide problem.

In the United States today there are an estimated million and a half persons with epilepsy. Of these, 75 percent, or well over a million, are under the age of 20.

Epilepsy is largely controllable. Now, through the use of anti-convulsant drugs and occasional surgery, seizures can be completely eliminated for 50 percent and for 30 percent reduced appreciably.

Therefore, 80 percent of the epileptic population, if properly treated medically, can live normal lives.

Of the remaining 20 percent, 15 percent can still function in everyday society to a limited extent with poorly controlled seizures, and the remaining 5 percent are institutionalized.

It is extremely important to remember that many persons have other medical problems along with epilepsy which are frequently more of a handicap than are the seizures. These conditions may include cerebral palsy, mental retardation, or emotional disturbances. Epilepsy is not ordinarily the cause of these complication factors, but merely coexists with them.

For centuries the epileptic has been considered unclean, possessed by demons, insane, and dangerous.

Even in this era of enlightened social conscience and medical sophistication, such attitudes persist.

For example, a history of epilepsy bars entry to this country even as a visitor. Likewise, a recent poll indicates that about 40 percent of persons don't want their children associating with children who have epilepsy.

It is largely this unreasoning fear and ignorance which complicates the educational opportunities for children with epilepsy. The epileptic is by no means stupid. It has long ago been statistically proved that the IQ of the epileptic population is as high, or even a little higher, than normal.

Most physicians and lay persons experienced in epilepsy feel that special educational facilities are not needed nor are they desirable for the epileptic child. Rather, he benefits from attendance at regular school classes. When this is not possible, he should receive special educational attention through existing community facilities.

The educational needs fall into three categories:

1. The children able to attend regular classes;
2. Those who must attend special classes;
3. Those who need home teaching.

A. THE CHILD WHO CAN ATTEND REGULAR CLASSES

The 50 percent with full seizure control normally are admitted to regular classes, but in some instances, school systems impose unrealistic restrictions through ignorance of the disorder.

Those children with partial control should also be admitted without prejudice to regular school classes. This is not taking place. They are not made welcome.

The Massachusetts Department of Public Health in a 1958 survey, found that only 67 percent of the 90 percent of children with epilepsy capable of attending classes, actually went to school. The reasons are:

1. Outdated attitudes about epilepsy;

2. Crowded classrooms;
3. The unpleasant nature of seizures cause teachers and officials to consider the child uneducable and disruptive;
4. Lack of epilepsy clinics and trained staff prevent maximal benefit from existing modern treatment methods;
5. Level of seizure control is less than that possible when optimal medical care is given;
6. Lack of public education in general, and lack of knowledge about epilepsy on the part of educators.

In Massachusetts, a State known for its medical sophistication, only about 50 percent of epileptics are treated. Nationally, this figure drops to a scandalous 20 percent.

The following suggestions are respectfully submitted for your consideration:

1. Encourage the establishment of neurology clinics by making funds available to communities for that purpose.

2. Encourage young physicians to specialize in neurological disorders by increasing research and training grants in this specialty.

3. Develop through the U.S. Public Health Service an intraining education program for physicians in subjects relating to epilepsy.

4. Make additional funds available through the Crippled Children's Services for the diagnosis and treatment of epilepsy.

5. Take an active role in eliminating ignorance of schoolteachers and officials through—

- (a) A national conference of educators about epileptic children;

- (b) Funds for local conferences of similar nature;

- (c) Provision of educational materials to school officials about epilepsy;

- (d) Encourage those colleges and universities who train teachers to offer more intensive courses in the management of the exceptional child.

B. THE CHILD WHO MUST ATTEND SPECIAL CLASSES

The 5 percent of children who must attend special classes do not require classes for epileptics only, but profit more by mixing with children with all types of handicaps. These children, however, are subject to the same prejudices which hamper the children who attend regular school.

Reports from school officials indicate that the demand for special instruction far exceeds the availability of classroom space and trained teachers. Consequently, many children do not have the benefit of special classes. Thus, many educable children become public charges rather than self-sufficient, economically productive citizens.

The following suggestions are respectfully submitted for your consideration:

1. Make funds available to local school committees for the establishment of special classes for handicapped children;

2. Provide transportation to and from school for these children;

3. Develop standards to guide school officials in placing children in special classes;

4. Offer fellowships to teachers who wish to specialize in the management of exceptional children.

C. THE CHILD WHO REQUIRES A HOME TEACHER

Epilepsy is not a static disability, nor one which worsens with age. Happily, seizures normally diminish with age. Thus, a child who, at beginning school age of 6, has frequent seizures, may very often have only occasional attacks at the age of 10.

Therefore, the young child who is able to learn, but who cannot attend school, should be given home tutoring so that he may be prepared to resume his education later.

Although many communities provide a home teaching program, it is usually inadequate because of a shortage of properly trained teachers.

The following suggestions are respectfully made for your consideration:

1. Offer fellowships to teachers with specialization for home teaching;

2. Offer Federal grants to school systems for the expansion of home teaching programs;

3. Make funds available for the exploration of TV as a home teaching tool.

Others will have spoken to you, I am sure, about the problems of the epileptic seeking employment. I ask only that you keep in mind one basic fact. It is fact beyond all conjecture that the reasons epileptics do not find employment easily is not because of their disorder, but because of other factors, such as lack of training, social attitudes, et cetera. Is it not reasonable to presume that one substantial factor is that the majority have not benefited from a suitable education? Epileptics are intelligent.

If we give them half a chance to get a normal education, they can become employed and economically self-sufficient. If we do not, they become public charges and nonprofit citizens.

Thank you.

Mr. GIAIMO. Thank you, Mrs. Grass.

Mr. WAINWRIGHT. What other organizations participate in the care of epileptics, your voluntary organizations?

Mrs. GRASS. I speak for the American Epilepsy Federation, which is a national organization of some 23 volunteer local organizations throughout the United States. There is no other similar organization which will not ultimately become a part of this federation. There are several which have not as yet joined.

But other than this organization, there are only organizations for professional assistance to the epileptic.

Mr. GIAIMO. Thank you, Mrs. Grass.

The next witness will be Dr. Wilbert Pronovost, professor, department of education, Boston University.

You may proceed as you wish.

STATEMENT OF WILBERT PRONOVOST, PROFESSOR, DEPARTMENT OF EDUCATION, BOSTON UNIVERSITY

Mr. PRONOVOST. Thank you very much. It certainly is a privilege to be able to appear before the committee and testify, especially to the House Joint Resolution 494 and all the other bills that are associated with it.

Boston University trains speech pathologists, audiologists, and teachers of the deaf-blind. It also provides a center for diagnostic and remedial services for children and adults with speech and hearing disabilities, and provides consultant services to public and parochial schools and rehabilitation centers.

Through our services and surveys, we can substantiate that the national estimate of 5 percent of the school population as handicapped by speech and hearing disabilities applies to the New England area. Individual schools vary between 3.8 and 6.5 percent.

In terms of the need for speech pathologists, we could have placed three times as many in New England as we actually trained. Vacancies now exist in all six New England States, which could not be filled by the anticipated number of 1960 graduates.

The 5 or 6 New England training centers will graduate only 50 persons for the estimated 250 vacancies which are expected in the 1960-61 school year.

Graduate fellowships are needed to encourage more individuals to enroll for training in speech pathology and audiology. The intensive specialized training at the graduate level requires additional expenditures which most students cannot afford after 4 years of graduate study.

Three-quarters of Boston University's present group of fulltime graduate students are receiving some form of financial aid from assistantships or fellowships.

Grants in aid are necessary to help a training center defray the costs of a training program which must include considerable individual supervision.

For example, the cost of adequate supervision of clinical practice at Boston University would be at least \$500 per student per year, exclusive of physical facilities. This is half of the total tuition paid by the student, although the clinical practice is only one-fifth of his academic program.

I submit in a private institution that has no endowment this takes some pretty fancy budgetary figuring to see how you are going to pay for it.

Obviously, we do need outside support for that. This cost does not include physical facilities at all. This is just staff, faculty, time.

The study group in speech and hearing which met at Yale during the 2 days prior to these hearings have reported that 1,027 speech pathologists and audiologists are needed in New England, with only 200 currently employed. In order to assume its share of responsibility, in expanding training facilities, Boston University would need to increase its present staff by at least 50 percent.

Mr. ELLIOTT. How many teachers are you graduating now?

Mr. PRONOVOST. This year we will graduate 18, only 9 of which we feel reasonably sure will be available to us in New England. Some of them will go on to further graduate studies. Some of them will go into other areas.

Mr. ELLIOTT. Your need each year on a yearly basis is what?

Mr. PRONOVOST. For New England alone at least three times that many that we could fill, taking into account our share.

Actually, our students, in terms of nationwide placement, have about 10 jobs for every student at the present time.

Mr. ELLIOTT. That is true of New England with that 1,000 backlog?

Mr. PROVONOST. Yes. In connection with another aspect of the bill dealing with teachers of the deaf, in 1956 a survey, conducted by the United Community Services, in Metropolitan Boston, recommended that a training center for teachers of the deaf be established in the Boston area. Boston University could expand its present program to implement this recommendation, but grants in aid to help defray expenses, and scholarships to encourage students to enroll in the program, would be required.

In light of the factors presented above, this statement supports the provisions of House Joint Resolutions 494 and 316 and urges action by the 86th Congress to meet an immediate need.

Thank you for the privilege of appearing.

Mr. GIAIMO. Are there any questions?

Mr. WAINWRIGHT. What is the title of your department?

Mr. PROVONOST. The speech and hearing section of the Department of Special Education at Boston University.

Mr. WAINWRIGHT. Do major institutions of learning, major universities, have similar departments?

Mr. PROVONOST. Yes. I don't know the exact number.

Mr. WAINWRIGHT. Under one title, or another, but performing the same function?

Mr. PROVONOST. Yes, under one title or another all of the major universities and most of the small colleges have such departments.

For instance, we have at least 30 to 35 that are providing doctorate degrees study in speech pathology and audiology at the graduate level and others at a less advanced level through the master's degree.

Mr. WAINWRIGHT. You point out the difficulty that they have and you have in raising funds for the continuance of the program during the course. Where do they get their money from, from State grants if they do not get them from Federal grants?

Mr. PROVONOST. May I point out on a nationwide scale there are a lot of State universities involved in these programs and they, of course, have State funds for this provision, appropriations by the State legislatures to the colleges.

Mr. WAINWRIGHT. How about Boston University? Does it get any help from the State of Massachusetts?

Mr. PROVONOST. No, we get no help at all. We are a private institution. This year we have some support for one small part of our program for the rehabilitation area of speech pathology and audiology from OVR. We have an OVR grant this year for a small part of our program.

Mr. WAINWRIGHT. Even under the guise of research or social welfare no contribution can be made to the studies?

Mr. PROVONOST. Contributions could be made, but we don't have any source that we can tap.

Mr. GIAIMO. Thank you, Doctor.

The next witness is Janet Swebilius, executive director of the Association for Retarded Children in Greater New Haven.

Mrs. Swebilius, may I say, as a fellow member and resident of New Haven, it is a pleasure to have you with us today.

We recognize your great interest in this field for many years.

We are glad to have you and you may proceed in your own way.

STATEMENT OF JANET SWEBILIUS, EXECUTIVE DIRECTOR, ASSOCIATION FOR RETARDED CHILDREN IN GREATER NEW HAVEN, CONN.

Mrs. SWEBILIUS. I just want to say I am director of the New Haven association, but I am also representing the State association.

We all want to thank you for coming here and looking into it.

Other speakers have mentioned the splendid bills that were passed at the last session of the Connecticut Assembly. These cover not only mandatory education and institutional charges, but the one of which we are most proud, the establishment of an office of mental retardation in the State department of health, which includes, most important of all, appropriations for diagnostic clinics, vocational rehabilitation centers and day care centers.

I would like to touch on some of these individually later on, but one purpose in mentioning these accomplishments at this time is that we feel there is a definite need for greater effort on the part of the Federal Government in coordinating and disseminating the information gained in various sections of the country in these fields.

As proud as we are of our legislative accomplishments in Connecticut, we realize that they are creating and will create problems.

The Mandatory Education Act, for instance, means a very severe teacher shortage in 1961 for the mentally retarded. Even though we are training more teachers for special education in Connecticut colleges than in any other section of the country we understand that there will be a shortage of 150 special teachers in this State in the next 2 years.

We feel that the Federal Government can assist in this respect by further strengthening of Public Law 85-926.

Further, in the area of diagnostic clinics the problem of adequate and appropriate staff is acute as is also the problem as to where such clinics should be located for the greatest service to the greatest number.

Even when adequate and appropriate clinics are established a serious problem exists in locating the mentally retarded at an early enough age to plan and counsel properly.

A good example of this is our own preschool class. Fifty-four percent of our children come from the outlying towns whose population is only 40 percent that of New Haven.

And we know that New Haven is not singularly blessed by not having retarded children. We just do not know who or where most of them are until they reach school age.

Here, again, we think the Federal Government can help toward proper education or perhaps the public health nurse who in many cases is the most important contact for the family.

With the finding of the mentally retarded as early as possible, families could be directed to the various day care centers and preschool training programs. From our own experience we know that the earlier we get the child for training the more likely it will be that he will adjust in the public school classes.

This, in turn, makes life easier and better for the child, the family, and the community.

For vocational rehabilitation centers we heartily endorse the passage of H.R. 6485, introduced by the Honorable Carl Elliott. We would hope that the intent will be clarified and that the severely retarded will be definitely included for rehabilitation.

There is a straight line to be drawn from early diagnosis through preschool training, special education, and recreation to vocational rehabilitation and job placement in either the community or in a sheltered workshop condition. We feel that there is an obligation of each agency of the Government to provide to the mentally retarded those services which are normally provided the average child as well as those which might be provided because of the condition of retardation.

With a continuing enlarged Federal participation and coordination the mentally retarded will become a national asset instead of an economic and social liability.

Thank you.

Mr. GIAIMO. Are there any questions by members of the subcommittee?

Thank you, Mrs. Swebilius.

Mrs. SWEBILIUS. Thank you, sir.

Mr. GIAIMO. The next witness will be Dr. Charles D. Marple, director of the Allergy Foundation of America.

STATEMENT OF CHARLES D. MARPLE, DIRECTOR, ALLERGY FOUNDATION OF AMERICA

Dr. MARPLE. I have no prepared statement.

Mr. GIAIMO. Did you wish to send us some prepared material?

Dr. MARPLE. Yes.

Mr. GIAIMO. Do you wish to incorporate it in the record?

Dr. MARPLE. Not at this time.

I am appearing here to bring to your attention a special group and will confine my remarks actually to two special groups within the entire field of allergic individuals. One group is the allergic children who suffer particularly from severe and intractable asthma, and the other is allergic adults with occupational or nonoccupational allergies whose abilities to earn an adequate living is either prevented or impaired by the disease.

Our organization, which is a national voluntary health agency of rather short duration, 5 years in all, has made a considerable effort to tackle these problems from the simplest to the most complex aspects, from statistics, determination of where facilities exist, to rehabilitation, and we find it exceedingly difficult to find information with which we can provide help, assistance, or even advice to these individuals.

It has apparently been the feeling in the past that allergy, including asthma, is not of very great consequence. There are very few statistics, very little information, and practically no special facilities for the care of these people.

It is now generally accepted, using Public Health figures, that at least 10 percent of our general population suffers from some sort of allergic condition.

A recent study which will be published next month by Dr. Robert Rapaport, of New York City, shows that in the average pediatric

practice about 20 percent of the children suffer from such allergies. If these children can be treated properly, if they recover from their disease they can become perfectly normal, self-sufficient adults.

As a matter of fact, they tend to have normal intellect and there have been some studies to show that they may tend to have superior intellects.

However, the general belief that they spontaneously recover from this type of disease is entirely erroneous. A very large percentage who are not treated or not treated properly become chronic asthmatics for the rest of their lives. These people suffer not only the physical detriment of asthma or the other allergic conditions, but they have a very severe emotional overlay.

The emotional health of the individual is impaired and the emotional life of the family is very much disturbed. This becomes a vicious cycle. You find more and more that these asthmatic children are disturbing to the family, pretty soon the children realize, subconsciously perhaps, that they can avoid all the difficulties in life by having their attacks, and we find that emotional episodes in the home will provoke these attacks.

The tragedy of all this is that this can be taken care of and prevented by good medical care, psychiatric or psychological evaluation and care and proper rehabilitation.

There are very few places where these people can go for this care unless they are fully able to afford the cost of private medical practice, including specialists in allergy, perhaps psychiatric care and so forth.

We have made some survey or attempted to survey the clinical facilities open to these people throughout the country. The reporting is not very good, but it is very tragic to see in how many areas in the country we could find no evidence of any clinic which gave the special care necessary to these children.

In one large city in New York State, one hospital answered our inquiry by writing on the back of the letter "We wish you could find a trained and skilled allergist to send to our city because we don't have one."

With the adults there is a problem which is, I think, no less important. In many industries the occupational hazards and in others the individual hazard of outside allergy, men are prevented from earning a proper living because of their allergy.

With the white collar class very often the plant or industry or the business will operate a clinic to take care of them.

With the unskilled laborer he may be able to go to an environment where he is not exposed to whatever he is sensitive to.

For the skilled or semiskilled laborer he very often has to drop to a lower economic plane in order to avoid the sensitivities which manifest themselves in asthma, skin dermatitis, and that sort of thing.

There are at least 3 to 4 million people in the United States with asthma. There are probably an equal number with other allergies which are sufficiently important to interfere with normal education and normal work.

At the present time the problem is not only a national one, but it is a basic one because there are no case finding records as far as we know. Except in private medical care there are very few places where these people can get total care.

There are very few special educational training programs for them. The number of institutions which give these people long range care with psychiatric aspects, vocational rehabilitation and that sort of thing, there are only about four in the country.

Most of the private hospitals will not willingly take asthmatic patients because they tend to be long range and they very often are not critically ill over that period of time.

The goals that are needed here are to start from scratch. First of all, we need more physicians interested in, trained in, and skilled in the treatment of allergic individuals. We need more special clinics and we need more hospital beds available for these people so that they will be treated in an environment conducive to their complete recovery.

We need special institutions where the intractible asthmatic may be treated away from the home environment which in the case of children is very often very detrimental because of the emotional conflicts.

We need special educational programs.

So far as I know, these are practically nonexistent. To our knowledge, although we have many inquiries about this, I know of only one summer camp in the United States where they take special care of asthmatic children. There are some others which take asthmatic children along with other children, but only one where we can recommend these children to for their special care.

In the matter of rehabilitation I think there should be a nationwide program in which, so far as I can see, only the Government can take leadership. There is not a sufficient interest in these conditions for private leadership and the matter is now broken up into a number of organizations that are trying to do a job which do not have the national strength unless the Government does give the leadership.

Mr. GIAIMO. Doctor, you stated there was a need for more physicians trained in the field of allergy.

Dr. MARPLE. Yes.

Mr. GIAIMO. What do you propose as a solution to that?

Dr. MARPLE. I don't know any solution other than by exposure. What we are trying to do in our foundation, we have two programs which we think will attract men. I don't think you can browbeat or force them into a specialty.

The thing to do is to expose them to it and make it attractive. Along with certain other organizations we are offering medical students summer scholarships during which they spend their summers working in research and doing clinical experience in allergy.

We hope this year to support 30 such students. A great many of these students do acquire a considerable interest in the field. They will not all become allergists, but they will become better doctors.

We also have postdoctoral fellowships which are available to persons already qualified in pediatrics and internal medicine.

We have only been able to award three of these so far. Our first postdoctoral fellowship will become the first full time instructor in pediatric allergy in Johns Hopkins where they are setting up their first clinic for pediatric allergy so they can continue research, teaching students and house staff in residence.

This is what we think is one of the basic needs. We need a lot more of these fellowships and scholarships.

Mr. GIAIMO. Are there any questions by members of the subcommittee?

Thank you for your testimony.

Our next witness is Dr. Hutcheson.

Dr. KLEBANOFF. I am not Dr. Hutcheson.

Mr. GIAIMO. Dr. Lewis B. Klebanoff will testify in place of Dr. B. R. Hutcheson, who addresses this letter to Carl Elliott:

Lewis B. Klebanoff, Ph. D., S.M. Hyg., is supervisor of the Preschool Nurseries for Retarded Children which are run by the Department of Mental Health, Commonwealth of Massachusetts. In my absence, I would like Dr. Klebanoff to read our joint statement about the evident needs for special education as they relate to the handicapped child. Dr. Klebanoff is fully authorized by me to answer any questions you may have about our statement.

Sincerely yours,

B. R. HUTCHESON, M.D., *Director.*

Mr. GIAIMO. Without objection by members of the subcommittee, we will listen to the testimony of Dr. Klebanoff.

STATEMENT OF LEWIS B. KLEBANOFF, PH. D., S.M. HYG, SUPERVISOR OF COMMUNITY MENTAL RETARDATION CENTERS, DIVISION OF MENTAL HYGIENE, MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH

Dr. KLEBANOFF. Mr. Chairman and members of the committee, the fact that your committee is soliciting testimony about the problems of special education and rehabilitation reflects the great interest and concern of our citizens for the needs of the handicapped child.

Of this group of unfortunate children, by far the largest number are mentally retarded and/or emotionally troubled. By and large it is these groups of children for whom the least extensive and least adequate services are provided despite the tremendous number of families in great need of help.

We support the general expansion of programs and services for all handicapped children, particularly the mentally handicapped. It is an historical fact and one of the hallmarks of this Nation's progress as a world leader in demonstrating what a democratic society can do for its afflicted citizens that the wisdom, foresight, and generosity of previous Congresses have not only stimulated, through various grants-in-aid, matching funds, research funds, and other projects, but actually made possible the beginnings of a great number of vitally needed programs and services.

However, in a dynamic, growing, help-thy-neighbor society, such as ours, much more is needed.

In the few minutes allowed us, we should like to present for your consideration two problems, the successful resolution of which will help to make more effective whatever legislation is adopted.

Problem No. 1 concerns the earmarking of various funds to a particular agency of State government.

You may not be aware of the fact that in Massachusetts the Department of Mental Health has historically had the major responsibility for mental retardation. The Walter E. Fernald State School was

opened in 1848. Special education for the retarded in the Boston public schools began at the turn of the century and it was only in 1919 that statewide legislation was passed providing special classes for educable and trainable retardates under the supervision of the department of education and a special division was not created until 1954.

The department of mental health, nevertheless, currently operates about 100 classes for handicapped children. Despite the organization of our State government and our own internal apportioning of responsibility, various Federal programs do not possess sufficient flexibility to adequately respond to our local needs.

To mention only two examples, various research funds of the Office of Education will be made available only to State departments of education or schools of education at colleges and universities and the Children's Bureau program for demonstration projects in mental retardation will apparently not consider any group other than a department of public health.

Briefly on this point, we are asking for legislation to be flexible enough to adapt to local laws and customs within the bounds of high purpose and quality and also to be broad enough to allow different states to fill in the particular gaps in their own programs.

We do not mean to imply that the other departments are not doing a good job with these funds, but are merely requesting expanded eligibility.

The second very important problem which we should like to bring to your attention is the very great need for depth and quality of programing. We have become concerned about the programs, for the retarded child particularly, which are undertaken with little or no understanding of the extremely vital importance of obtaining an adequate medical, psychological, and social diagnostic evaluation.

A comprehensive study of the child by an integrated team of physicians, psychologists, social workers, speech therapists, teachers, and others not only may uncover remediable defects, but can help to plan an educational program for the child by placing in proper perspective not only his handicaps, but his strengths and potentials.

These considerations, of course, apply also to the emotionally disturbed child.

Today, unfortunately, too many children have their educational and rehabilitative courses charted for them on the basis of very meager evidence obtained from a brief intelligence test or briefer interview by semitrained people who have not had the proper preparation for the jobs which they are doing.

What if the law allowed your child to have his tonsils removed by someone who had read all of the books and taken all of the courses, but who had never observed, let alone performed, a tonsillectomy.

Unhappily, many of these crash programs to make psychologists, social workers, or guidance workers out of teachers who take courses evenings or summers fall into the same category. There is no provision made for supervised field experience under a fully qualified senior worker.

We feel that these provisions are lacking in brief training programs essentially because the statutes do not insist that they be provided.

Public health law, on the other hand, attempts to protect the citizenry from adulterant chemicals in food, inadequate strengths of medicines, and in some programs insists on its money only being used for personnel serving within the provisions of merit systems which set professional standards. Thus, there is legal precedent for this approach.

Having a flair for working with children is a necessary but not sufficient condition for being a professional, just as the good will and motivation for helping the handicapped is not sufficient to guarantee sound legislation, but requires, in addition, a careful evaluation of the needs of a particular group and the resources available to meet those needs.

Let us not loose upon the community people from whom the public will expect, because of their titles, services which they are woefully inadequate to perform. Such workers, however well intentioned, frequently cause a great amount of harm to families when they overreach their limitations.

It is clear that, at least for the foreseeable future, our demands for trained personnel are going to outstrip the supply. Expanded training funds for universities, hospitals, and clinics are needed, as well as training stipends to encourage our able college students to accept the time-consuming, rigorous discipline of full professional preparation.

Where it is necessary to utilize less than fully trained personnel, we urge that legislation specify that these persons work in a setting in which they are supervised by a fully trained professional.

In this way, we will be better able to deal with the great demand for personnel while protecting the public whom we are serving.

In summary, we need more and better programs to serve the handicapped, comprehensive programs that provide for a continuity of services based on adequate diagnostic studies with therapeutic and educational prescriptions.

We need Federal funds to be more flexible in order to adequately meet the needs of the various States and we need your help in protecting the public from a flood of semiprofessionals with inadequate training.

We should like to leave with you for your subsequent consideration a summary of proceedings of the Governor's Conference on Mental Retardation called by his Excellency, Gov. Foster Furcolo, of Massachusetts, on May 26-28, 1959. This conference was a big stride forward for our Commonwealth and was made possible by a grant from the Community Services Branch of the National Institute of Mental Health.

Thank you for your courteous attention and the opportunity to address you.

MR. GLAIMO. Thank you, Dr. Klebanoff.

Are there any questions by members of the subcommittee.

Thank you very much for your presentation, Dr. Klebanoff.

Without objection, the summary of the proceedings of the Governor's Conference on Mental Retardation will be made a part of the record.

(The summary referred to follows:)

SUMMARY OF PROCEEDINGS, GOVERNOR'S CONFERENCE ON MENTAL
RETARDATION, NEW OCEAN HOUSE, SWAMPSCOTT, MASS., MAY 26-
28, 1959

SOME PERSPECTIVES ON THE CARE OF THE RETARDED CHILD

(By E. N. Rexford, M.D.)

A Governor's Conference on Mental Retardation, which brings together citizens, governmental officials and professional persons, gives appropriate recognition to the fact that our resources today are mobilized with a renewed concentration upon the needs and problems of the retarded child.

That the Governor of Massachusetts calls such a conference is a peculiarly fitting circumstance in view of the great contributions which Massachusetts citizens, with the frequent cooperation of the legislature of the Commonwealth, made to the early measures for study, training, and care of mentally defective children. You may not all be aware of the fact that these efforts on behalf of retarded children were practically the only psychiatric efforts with children from about 1846-1909. The stimulus for such work came from the reports of French psychiatrists, Itard, his pupil, Edward Seguin, and others who were experimenting with services for mentally defective children.

In 1846, an experimental school for mentally defective children was established by an act of the Massachusetts Legislature at Perkins Institute for the Blind, under the supervision of Dr. Samuel G. Howe. In 1848, Seguin came from Paris to take over the superintendency of the school which was then incorporated as the Massachusetts School for Idiotic and Feeble-minded Children. It was later renamed for Dr. Walter E. Fernald, its superintendent from 1887 to 1924. Dr. Harvey Wilbur of Barre, Mass., was another pioneer who in 1848 took into his home for training a retarded boy.

These and the measures later developed in other States operated with the primary aim of filling in gaps in the educational system, yet, interestingly enough, all of these pioneering schools and projects were headed by physicians. The education of defective individuals was seen only in terms of institutional training and, in France, this focus persists very much to the present day.

In the United States, however, developments took place along several lines: the setting up of colonies, boarding homes, parole and supervision programs, recognition of and separation out of the delinquent defective group, provision for special classes in the public schools, courses of training for special teachers, etc. In each of these developments, Dr. Fernald played a central role in pressing for the support of such activities from the various legislatures, the medical profession, the educators, and the lay public.

Incidental to these interests, Dr. Fernald extended to many other types of children the benefits of psychiatric understanding and approach. The years 1893-1909 saw the first sustained approach of actual and scientific study of children as such. G. Stanley Hall, of Clark University, and Adolph Meyer, of Baltimore, were influential in setting up the National Association for the Study of Children.

The era of the child-guidance clinic began specifically with Dr. William Healy, who in 1908 wrote of his travels about the United States: "With the exception of Witmer in Philadelphia and Goddard at Vineland, there was not even the semblance of anything that could be called a well-rounded study of a young human individual. Even physiological norms were not available; standardized mental tests had yet to be developed; the importance of knowledge of family attitudes and conditioning was barely realized." The child-guidance movement involved multidisciplinary study and treatment of children with a wide variety of emotional and behavior difficulties—first, particularly the delinquent; then, later, the neurotic; and, more recently, the psychotic child. In these programs the retarded children have been included, but not in large numbers; the early training and educational programs for them have continued in parallel development.

I have spent some time outlining the historical developments, not only because I wished to put before you various interesting facts and, incidentally, give all of us a certain chauvinistic gratification, but because I believe that historical perspective can help us see more clearly where we are today and where we need to look for tomorrow's efforts.

Our American society has been characterized by both native and foreign observers as unique among Western groups in our concentration upon the welfare of our children, in the expected participation of specialists, government officials, and lay citizens in programs of child care, and in our demand that any need for children, widely perceived and strongly voiced, be met speedily and effectively. As one born and reared in this country, I naturally partake readily of our expectations, hopes, and collaborative efforts. As a child psychiatrist of some years' experience, I am acutely aware of certain realities which can and do impinge upon the accomplishments of specific tasks our society or groups within it demand of our governmental agencies and of our professional personnel.

I noted for you the date of Dr. Healy's survey of services for children, 1908, just 51 years ago. During this half century, we have made significant strides in our understanding of children, of family life, of disturbances in expectable development, and concomitantly in our knowledge of useful services for children. Over the past 10 years, leaders in the field of child psychiatry and the related professional groups as well have been facing the fact that we have been applying what we have known, but lagging behind in developing new knowledge of human behavior. Many of the children who come to our clinics, and others whom someone wishes to refer, for example, are not effectively understood or treated on the basis of our present knowledge. This unhappy reality applies, for instance, to many delinquent children, psychotic boys and girls, and to many retarded children. It is natural for those concerned with the problems of delinquency, psychosis, retardation, and other serious social and emotional ills of children to decide that more services of the kind we have will provide the solutions they seek. It is true, I believe, that some progress can be made by expansion of all children's services; such expansion will require large sums of money for training new personnel and for maintaining the expensive highly specialized services involved. Whether as a nation we are ready to face the need for heavier taxation and for increased private giving, I do not know. What I am convinced of, from my experience in three Boston child psychiatric clinics, is that our present professional resources cannot be stretched much further.

Of even more significance is the concept of the crucial necessity for careful systematic research in the areas of child and family life which we too little understand today and the subsequent development of methods and techniques based upon that new knowledge which can provide us with new and improved tools for service, for guidance, and for program planning. Nowhere is this reality more apparent than in the field of mental retardation.

A child psychiatrist is often told by those specializing in work with retarded children that his experience is too limited to be of much value as a contribution to broad programs for such children. It is true that we see a relatively small number and perhaps a special group in our clinics and private practice. I found it interesting and encouraging that, having written down last week the points I wished to make to you tonight, I found myself in good company over the weekend as I perused the new survey by Masland, Sarason, and Gladwin called "Mental Subnormality, Biological, Psychological, and Cultural Factors." We were in agreement, I found, in the impression that we do not know many of the most basic facts involved in the etiology (the causes) development, the groupings, and the management of children who are intellectually handicapped. Many of the beliefs, both privately held and publicly expressed, regarding the retarded child are based on nothing more scientific than folklore, prejudice, or anxiety.

Research in the field of mental retardation must be approached from a variety of angles and must involve the participation of persons from many specialties. The role of central nervous system damage, which is Dr. Masland's special area of interest, cannot be well understood without basic studies in pregnancy, embryology, early infancy infectious disease, and immunology in childhood, which are not presently available to us. My own work with children who have learning difficulties salted by an old interest in and much ignorance of child neurology long ago persuaded me of the importance of our building a solid floor of knowledge about this area, the so-called organic factors in retarded learning processes.

Drs. Sarason and Gladwin write particularly of the work which has been done regarding the psychological and cultural factors in mental subnormality and document brilliantly the flimsy base upon which so many programs and services have been built. They raise trenchantly the question, "What is the nature and structure of intelligence?" and illustrate from the literature how confused and unsatisfactory our understanding is of this "faculty." What psychological tests

test and what they do not, whether normal expectable functioning in the school or test situation is a valid ground for predicting functioning in the outside world or in adult life situations—these are basic questions for our everyday work with retarded children. The influence of social and cultural factors upon the picture of retardation we see in the child and upon our planning for him we know far too little about.

With the specific suggestions for research areas of these authors I am in full agreement, but even more important, I believe, is their recommendation for research groups set up in conjunction with large university and medical school research institutes to stimulate the studies of many specialists using a wide variety of techniques which can be integrated to provide us with an ever-broadened body of knowledge regarding many facets of the problem of mental retardation.

The investment of time and money required for such endeavors will be large; most of the funds must undoubtedly come from governmental sources.

Closely related to the development of such research groups is the suggestion for training key personnel to work with retarded children in settings which can profit by the scientific, multidiscipline approach to the problem. Such a master plan would, I believe, serve as an important stimulus to recruitment of talented, skilled personnel for the study and care of retarded children, at present a difficult problem in itself.

The need for special training of the nursery school teacher, the public school teacher, the social worker, the psychologist, the psychiatrist, who are going to work with retarded children is a very important reality which must not be overlooked in setting up services and expanding others. If we are to provide the opportunity for each American child to be educated according to his need and capacity, Dr. Fernald's goal, we cannot ignore the fact that while some people's interest, native sympathy and professional skills may indeed contribute to the child's progress and general welfare, the addition of understanding of the retarded child's particular problems and needs will obviously increase the effectiveness of the professional effort on the child's behalf.

In closing, I would like to emphasize a fact so obvious that my comment may sound banal, namely, that retarded children are first and foremost, children. This means that they have the basic needs of all children for a warm, reasonably consistent and supportive family life. It means that we must understand that with this child as with a child intellectually normal each parent interacts according to the parent's own personality and maturity, influenced by the meaning this child has for him. When a child is handicapped in whatever fashion, different problems of adaptation for parents and child are added to those already intricate and demanding in any parent-child relationship. This is the area in which the psychiatrist is particularly at home; he has occasion daily to ponder the mysteries of the bearing emotional relationships have upon learning.

This is an area little explored in the Masland-Sarason-Gladwin survey, an admittedly difficult area for systematic research. Without more understanding of it, I believe we will handicap our efforts over and over again. If professional and parents' groups concentrate upon services for the retarded child which leave out this area of parent-child relationships, we may lose one of our most vital sources of understanding and therapeutic advance. Our conference is entitled "The Governor's Conference on Mental Retardation." The excellent survey to which I have referred is entitled "Mental Subnormality." Let us not in our serious efforts together on his behalf forget that the boy or girl we wish to help is a child, a retarded and handicapped child, but first and foremost, a child.

THE RETARDED CHILD AND THE COMMUNITY—A NATIONAL VIEW¹

(By Martha M. Eliot, M.D., professor of maternal and child health, Harvard School of Public Health)

During the past decade there has been a great upsurge throughout our country in citizen interest to find ways of providing more adequate community facilities and services for mentally retarded children. This interest is increasingly centered on the young child, even the newborn infant, for it is in this period of life that the diagnosis should be made, if possible. Federal, State, and local gov-

¹ An address given at the Governor's Conference on Mental Retardation at Swampscott, Mass., May 26, 1959.

ernments and many private organizations of professional and citizens' groups are deeply committed to learning about causes of mental retardation through research, to the provision of improved health, educational and welfare services for these children, and to the process of training personnel in many professional fields.

Local diagnostic facilities are being established under various auspices: some with State and local funds either those of health departments or mental health agencies; some with funds made available through the Children's Bureau in connection with the maternal and child health services of State and local public health agencies; some by private organizations, especially parents' organizations, and through private mental health clinic facilities. Special nursery schools are being developed. Physicians, public health nurses, child welfare workers, and teachers of young children are discovering that there is a great deal that can be done to help parents understand their children, learn how educable children can be taught, how trainable children can be given the help they need to learn to care for themselves.

In many institutions and training schools for mentally retarded children a new look at services and facilities is being taken in order to make available those required for more adequate care and education and to provide for the hospital type care needed by the most seriously handicapped.

Much community action has been initiated by the National and State associations of parents (of retarded children), such as the Massachusetts Association for Retarded Children. For more than a decade these associations have been working indefatigably to obtain national and local, public and private funds to accomplish their objectives.

It is of real significance that the parents of mentally retarded children, who banded themselves together in the National Association for Retarded Children, established, as one of their early acts, a committee of experts and scientists to explore the need for basic research and to seek funds to support research. The work of this committee under the leadership of Dr. Grover Powers of Connecticut has been very important, indeed, for it has been instrumental in stimulating many scientists to carry on research in this field of mental defect and in helping to find funds for this purpose.

In 20 States there are now official commissions established within recent years by a State legislature or Governor to consider State responsibility toward the mentally retarded and to recommend legislative and administrative changes at the State government level. Massachusetts is one of these.

It is about this nationwide interest in what the States and communities, the citizens, and professional and nonprofessional organizations are doing that I want to speak, especially the community aspects of work in behalf of your children. Though interest, activities, and financial support have been growing rapidly on a national as well as a State and local basis, the responsibility for the direct services to assist parents with their problems has always been assumed by statewide or local agencies. Likewise, research and training of personnel in this field, as in many others, are matters that greatly concern universities, official and private agencies, and research institutes at the local level. The role of the Federal Government is principally to take an overview of the total problem, to provide technical and financial assistance, to coordinate investigators and program planners, and to open channels for the exchange of information thus new knowledge of scientific facts and of methodology for the operation of programs may be made widely available. Within the framework of National, State, and local government, and private agencies and organizations at all levels, there is, indeed, a new and vigorous trend toward improving the care of mentally retarded children.

What are some of the facts that underlie this need to make local resources available and to stimulate research and training?

I would like to look first at the size of the problem.

It is commonly reported that about 30 out of every 1,000 of the total population (3 percent) are mentally retarded. This means a total of some 5 million persons of all ages. From this we can estimate that there are probably about 1¾ million retarded children under 18 years of age. Of these it is variously estimated that about 75 to 85 percent fall into the group described as educable, about 15 to 20 percent into the group described as trainable, and only about 3.5 to 5 percent into the group of severely retarded.

Within this average figure of 30 per 1,000 for the total population, there is, however, a wide variation in the number of children who are found to be retarded at different ages. For example, one study of the prevalence of retardation in different age groups showed a suspected rate of 4 per 1,000 among the 1- to 2-year olds. For the 3- to 4-year-old children a rate of 6 per 1,000 was found; for the 5-year olds, 22 per 1,000; for the 6-year olds, 40 per 1,000; and for the 10- to 15-year-old group, 80 per 1,000. Clearly, this apparent increase in rate is only a reflection of our inability to discover at the earlier ages the evidence of the relatively large number of mildly or even moderately retarded children which begins to show up when the children go to school.

To some of us it may be surprising to learn that only about 159,000 mentally retarded persons are in institutions and training schools. This figure is an estimate only and includes persons of all ages. Individuals in institutions represent about 25 percent of the seriously defective, about 15 percent of the moderately retarded, and only 1 percent of the large group of those who are slightly retarded. The number of children under 18 years of age in these institutions is not available, but we know that it must represent a very small proportion of the total number of retarded children.

It seems to be generally agreed that institutions should be given the responsibility for the care of three types of person, "the severely retarded who are totally dependent, the less retarded who are unable to integrate into society because of emotional disturbances leading to antisocial and delinquent behavior, and a third group, the older adult retarded who are dependent because their families * * * can no longer care for them."² Included within the first category are infants and children who are bedridden and wholly dependent on others for their care. For such the States must provide hospital-type care.

It is not always easy to decide when a child needs to have institutional care. In the past, no doubt, too many children have been placed in training schools and institutions when they might have been cared for at home. Thanks to the initiative of the many local groups of parents, and of their National Organization for Retarded Children, more and more people in authoritative places are becoming aware that many mentally retarded children can develop more successfully if they live at home in the family circle with its warmth of human affection than if they are removed to institutional care. Actually more than 95 percent of mentally retarded children do live at home. This means that heavy responsibility rests on State and local, public and private agencies, and on individuals who care, to see that community resources are made available to help parents understand their problems and give the necessary care and training to their children.

When society faces a problem that is as vast and as widespread as is mental retardation, it is obvious that we must look for ways to break it down into manageable units of activity by determining groups within the total that are at greatest risk and that can be singled out for specific attention; by developing special services for early case finding, diagnosis, evaluation, and followup; and by pressing forward with research that will sooner or later produce the knowledge necessary for prevention, with programs of training for all types of personnel who work with parents and children alike, and with ways of informing the public generally as to the nature and scope of the problem and society's responsibility to help in its solution.

It is not necessary to discuss here the paucity of our knowledge of the causes of mental retardation, or to urge you to support research that will throw light on causation or on ways to improve methods of diagnosis, treatment, education, training, and care of retarded children. Nor do I need to urge you to take continuing interest in research that will result in improved patterns of community organization of the multiprofessional services and facilities required for adequate care for these children.

Many, though still not enough, basic studies³ in the fields of medical research and genetics are in process in universities or research institutions. The National Institutes of Health, in addition to their training grants, are supporting research on the basic etiological factors in mental retardation and allied disorders, such as cerebral palsy. These studies range from many individual investigations of metabolic processes to that very comprehensive, 5-year col-

² "New Directions for Mentally Retarded Children—A Report of a Conference," published by the Josiah Macy, Jr., Foundation, New York, p. 101.

³ Garrison, Mortimer, Jr., "Research Trends in Mental Deficiency." *Children*, January-February 1959.

laborative study (in 15 medical centers) of cerebral palsy and other neurological and sensory disorders of infancy and childhood now going on.

Clinical and operational studies may be expected to develop before long in connection with the evaluation and treatment clinics for young retarded children that are supported, at least in part, by Children's Bureau funds. The Office of Education has contracted with various educational institutions for research in six areas: (1) the definition and identification of the mentally retarded; (2) learning characteristics and responses; (3) language and communication difficulties; (4) teaching methods and procedures; (5) the effects of different types of school organization; and (6) postschool adjustment and other problems.

In the behavioral sciences new trends of research are appearing directed toward studies of special difficulties that may exist, such as the importance of psychogenic factors in inhibiting mental development (Woodward and co-workers), the process of abstraction (Griffith and Spitz), or the importance of specific handicaps of retarded children with visual or auditory perceptual difficulties (Hunt and Patterson). In addition, other investigators are evaluating the effects of socioeconomic condition, language barriers in school performance, and numerous other subjects that will throw light on what is missing in the learning, thinking, problem solving, personality, and socialization of the mentally retarded child.

In spite of the great impetus that has been given to research recently, the problems waiting to be solved that are related to prevention are so complex and so greatly involved in metabolic, genetic, and physical factors that it may require many years to determine with accuracy the many different factors that may be involved. It is not necessary, however, to await all the new knowledge that sooner or later will come along before we proceed with programs of training and care. Fortunately, we do have sufficient understanding of child development to evaluate the degree of retardation sufficiently well to allow us to get on with our services for the retarded child and his family.

For example, we know that as a child develops in infancy and passes through his preschool years, certain stages of growth and development can be observed, and estimates may be made, in general, as to how well any particular child is doing. We know, moreover, that this growth and development process is not just physical or physiological. From early infancy on it involves the child's social and emotional behavior, his ability to perceive, and, a little later, his ability to begin to use his mind in the realm of ideas, form, creativity, and association. It is not too easy or simple to arrive at exact measurements of a child's mental and emotional development at any one point in these earliest years, or to understand when an emotional situation is getting in the way of a child's intellectual development and giving the effect of retardation. On the basis of a single observation it may be dangerous to predict what the future holds.

However, when a pre-school-age child is under the continuing observation of a good teacher in a nursery school, it may be possible to detect the first, slight evidences of slow learning. It may also be possible with an adequate diagnostic service to discover that some retardation is not the result of organic defects, but is emotional in origin and the result of some deviation from the usual pattern of personality development. Though slight variations from a so-called normal standard may be hard to detect and even harder to evaluate in the early years, it is, however, possible to reach broad judgments in the moderate or more severe types of retarded development. All of this and more is involved in the diagnosis of mental retardation in the young child.

That a child is put to a real test when he enters school and begins to work with symbols, ideas, and forms, such as letters and words and numbers, is well recognized. It soon becomes evident which children can learn unusually quickly and easily, which ones fall into the usual or "normal" group, and which ones are the slow learners. For many children, indeed, school is the first place where they can try out this intellectual process. This may be especially true for those who come from homes where study and reading or other forms of creative activity are not important in the family culture or not available for various socioeconomic reasons.

The health supervision programs for so-called normal preschool children is perhaps the best casefinding device we have for this age group, not only for many different types of physical defects and handicapping conditions, but for mental defects. It also serves as an agency for the referral of such children to other clinics or to private physicians for followup care. Increasingly, physi-

cians and nurses who form the basic team in such child health services are paying attention to the mental, emotional, and social development of the children, and, when some deviation is found or suspected the child and his parents are referred to whatever community resources exist to help with the particular problem. That there should be such special resources easily available to all communities is apparent to us all. However, unless the physician and nurse, hopefully with consultation from a social worker, are aware of these resources and understand the skills of referral, the special resources may not be utilized early.

The child health conference or the private practitioner's office may be the place where the parents of a mentally retarded child face the problem frankly for the first time. How the first discussions between doctor and parents go may speed the day when a program of good training and care is started for the child or it may result for the parents in the frustrating process of shopping around from one clinic or doctor to another in the vain search of a diagnosis they want to hear. Many times the responsibility for starting parents on a constructive program of help to their child rests with the child health services, be they in a public clinic or a private doctor's office. One of the best reasons I know why State and local health departments should develop good infant and preschool child health supervision programs in every community is this need to provide for any child the kind of help and care that each one requires for the best possible start in life.

But neither the private physician nor the child health conference can successfully handle all kinds of problems alone. Just as the parents of a child who is thought to be deaf must be referred to a special clinic or to a specialist for diagnosis and followup care, so must the parents of a child who is suspected of being retarded be sent to a special clinic or to a group of specialists for diagnosis and followup care. Recent experience has shown quite clearly that the usual infant and preschool child health supervisory service needs to be supplemented with a specialized clinic for evaluation and diagnosis of those children who are suspected of being retarded and for continued special help needed by parents. If these special clinics are under the auspices of a local health department which operates well-child clinics for normal children, then there can be cooperation between the regular and special clinics, routine immunizations can be done, and the public health nursing staff will be available to work in special clinics and do home followup.

Interestingly enough, we have parents themselves to thank for pushing forward this type of specialized clinic service until, as I shall point out, it is now becoming an important part of our State and national child program.

What was it that brought this about? Clearly the movement stemmed from the fact that parents of young moderately or severely retarded children were not getting the help they wanted from their doctors in the first place, or when they shopped around from one professional worker or group to another, in most cases they were still left alone with their problem of what to do after a diagnosis was made.

In many homes suspicion and often great anxiety that all was not well with a child's development had been aroused early, perhaps very early in the preschool years. From longtime habit such parents turned to the physician who had been giving the usual care to the child in sickness and in health. The results of such a consultation may or may not have been satisfactory to the parents, depending on a number of factors. These included the physician's own understanding of mental retardation, his skill in helping parents with the day-by-day process of training their child to help himself, and, lastly, his knowledge of what other resources there were in the community that could be used to give additional help to the parents. Unfortunately, few practicing physicians had had any training or much experience in this respect and few communities had any specific help to give them. This was where we were a decade ago. (Of course, over the years there have been a good many physicians, like Dr. John Thomson, of Edinburgh, who have had great interest and skill in helping these parents. But the great majority of doctors had little to offer because they have been taught so little in medical school.)

It was in 1949 in New York—so Hormuth reports⁴—that the first group of parents of mentally retarded children determined to establish a special clinical facility where they and others could get the kind of help they wanted—a thorough

⁴Hormuth, Rudolph P., M.S.W.: "Community Clinics for the Mentally Retarded." *Children*, September-October 1957, vol. 4, No. 5, p. 181.

diagnosis, interpretation of findings, and continuing guidance and management supervision. This was the kind of help they knew they could get if their child had, let us say, rheumatic fever or poliomyelitis. Why not for mental retardation? The clinic was an exploratory demonstration, and it succeeded.

Five years later, in 1955, the National Association for Retarded Children could report 33 such clinics with 12 additional in the planning stage. By 1956 the association was ready to go to Congress and seek additional appropriations to the Children's Bureau for grants to States under the maternal and child health program for the development of public community clinics where parents could go with their retarded children and be sure that they would get the continuing help of doctor, nurse, social worker, psychologist, psychiatrist, and others as they needed it.

It is a matter of very great satisfaction that the Congress recognized that the Federal Government, through the Children's Bureau, should assist States and communities in this work with part of the grant-in-aid funds appropriated annually for maternal and child health. As in all other programs of Federal aid to the States for child health and welfare services, the most helpful role that can be played by the Children's Bureau, besides supplying funds, is that of carrying fruitful ideas from State to State, from community to community, and helping with the development and adaptation of those ideas in the different settings and cultural patterns of each State or community. It is likewise a matter of satisfaction that the principle of equalization of opportunities for children, no matter where they live or what their socioeconomic circumstances, was recognized once again, and this time for the care and training of mentally retarded children.

When the Congress decided to earmark some of those grant-in-aid funds for community projects for the care of these retarded children, it showed great foresight in determining the program from which the funds would be taken. By choosing the maternal and child health program rather than that for crippled children the Congress placed the responsibility with those State authorities that already had the responsibility for preventive health services for all children. It was recognized that mentally retarded children, like all other children, would also need medical care when sick, or other special services when crippled or emotionally disturbed. It was clear that these children would need child welfare services and opportunities for training in nursery schools, and that the parents would need much careful counseling and continuing support.

From an administrative point of view, this new program was not very different from other specialized services under the maternal and child health program. In an article discussing the implementation of the congressional action, published in the *American Journal of Public Health* in January 1959, Dr. Arthur Lesser⁵ points out that "the basic interests of the MCH program—early case finding, preventive health services, child health supervision, mother-child and family relationships and the growth and development of children—are also the basic interests of a program for mentally retarded children." He explains further that, through the MCH programs, special diagnostic and followup clinics can be set up, and health, education, social casework, mental health, and other medical resources of the community or State made available to these children. The regular help of public health nurse and child welfare worker, of hospitals and clinics, nursery schools, kindergartens, and early elementary school grades, and other local services of public or private agencies can be called on to help. (The basic workers in this program will be those who are dedicated to the fundamental principles of prevention and to finding ways for the attainment of the highest level of development—physical, mental, and social—of which each individual child is capable.) (They will be workers who are aware of the wide range of intellectual, emotional, and social potentialities in young children.)

In other words, as this program expands and grows, it will work through already existing channels for child health; it will utilize all resources of the State and local mental health programs; it will serve as an early case-finding resource and a referral agency. Locally such a clinical service, regardless of its administrative auspices, can serve as a focal point to which many activities for mentally retarded children can relate themselves.

I am happy to say that we have a demonstration of just this type of combined service for young mentally retarded children and their parents in Cam-

⁵ Lesser, Arthur J., M.D.: "New Program for Mentally Retarded Children," *American Journal of Public Health*, January 1958, vol. 48, No. 1, p. 9.

bridge. Here there are seven regular child health clinics for any child whose parent wishes to make use of them. In addition, however, there is a special clinic for mentally retarded children, staffed partly by health department staff, partly by staff assigned by the local mental health clinic. One of the 24 State department of mental health nursery schools or centers is associated with this clinic for mentally retarded children. The local public health nurses carry some of the work for the special clinic and are the chief source of referral of children to this clinic for evaluation and followup care.

For this evaluation and care the special clinic makes available a pediatrician, a psychiatrist, a psychologist, a social worker, a public health nurse, and a social scientist as coordinator. Other staff of the health department are also available as needed. One of its chief values to the community is that it is closely associated with other child health activities, and the staff are well aware of all the resource potentialities for extended service of the greater Boston community. Another value, that has already been initiated in the Cambridge clinic, is its use as a training center for physicians, nurses, and other professional workers. Its potential use as a research center is not being overlooked. This is the type of local service that I wish was available in every center of population of 50,000 people throughout the country. Perhaps here in Massachusetts the nucleus of such cooperative clinic centers exists now in the 24 nursery centers to which Dr. Farrell has referred.

What the earmarking of Federal maternal and child health grants does, then, is to help to spotlight the problems of these retarded children in the communities and make possible the establishment of new ways to meet their needs along lines found useful in the care of other children with special problems. Already under this program special demonstration projects have been approved by the Children's Bureau in 36 States and in 8 additional States similar projects have been started with Federal or State money not earmarked for this purpose. This latter group of projects is of particular significance since they involve funds which might have been used for many other purposes, but, because of local interest, they have been set aside for this particular purpose. The general objectives of these projects, regardless of source of funds, are threefold: To provide helpful services to parents and children, to study the services and explore ways to improve them, and to serve as training centers for personnel needed to staff new or expanding programs.

All told, counting both public and private projects, there are probably now more than 75 special clinics in this country for preschool and young children who are retarded. To these should be added an unknown number of mental health clinics that are serving at least to some extent as diagnostic or evaluation centers for retarded as well as emotionally disturbed children, as here in Massachusetts.

This is a very creditable achievement, but it is only a beginning. It will take time to provide services and facilities for all the communities that need them. Two major stumbling blocks to more rapid expansion exist—enough personnel trained to do this kind of work, and funds to pay for the services, for training personnel, and for research to evaluate the programs as they go forward.

One obvious need, which is beginning to be met, is to enrich and amplify the education of medical students and practicing physicians with what knowledge we have of mental retardation and to give to them an understanding of the research that is required to extend that knowledge if we are to find pathways to prevention. If practices in communities are to be improved, physicians must be alert to current methods of diagnosis and followup work with parents in the care and training of these young children. In the course of their education, whether in medical school, hospital training, or postgraduate work, one of the things that a physician must learn is that he need not stand alone in his effort to help these parents. He may hear this theoretically in the classroom, but he will learn it most effectively if he can join with a team of workers—pediatrician, public health nurse, social worker, nursery school teacher, psychiatrist, and psychologist—and, indeed with the parents themselves, who are together operating a community clinic specially designed for mentally retarded children. Each of these workers has his own particular way of helping, but there is much to be gained if they work together as a team, each fulfilling his role at the appropriate time and place, and pooling with the others the results of his observations and efforts.

I have emphasized the role of the physicians, because experience shows that parents of young children do turn frequently to him first, and he has the greatest

number of chances to start parents on the most productive road to success with their children. However, any professional worker in the course of his regular work in a community may be the first to learn of the anxieties and receive the confidence of parents who are worried about their child's development. It is important, then, that a fundamental knowledge of child growth and development, both theoretical and practical, and of deviations from the normal should be included in the training of all of them. This goes for nurse, social worker, teacher, psychologist, as well as for physicians whether their primary focus is in the health, education, or welfare fields. That there should be a satisfactory diagnostic and followup clinic for mentally retarded children in which practical experience can be given would seem to be an essential part of this professional education.

Another part of this educational process, often overlooked in medical teaching, and not too well developed in any professional training, will have to do with the art of communicating ideas. It is often hard enough for physicians to explain to parents about some physical condition in their child. When they attempt to explain to an anxious parent that his or her child is mentally retarded, it becomes doubly difficult, partly because the doctor does not know too well how to impart the facts so that they will be understood, and partly because many parents, though they hear the words that are spoken, are too anxious and disturbed to take them in. Since, however, the doctor is so often a key person when the child is still very young and the parents' problems are most acute, special attention may well be given to helping him understand how to get his ideas across to the parents and how to secure the help of other professional workers who can supplement what he does by visits to the homes.

Next in importance to training personnel for work with mentally retarded children, if ultimate success of this program is to be assured, is the need to study the methods of work on a continuing basis. I am happy to say that in a number of the special demonstration projects plans have been laid to record and analyze data in ways that will help the directors of the programs to evaluate the progress they are making. This type of so-called built-in evaluation, if it is systematically and objectively followed, should point the way to rapid improvement in the total program.

Lastly, I would like to reiterate the conviction of many who are struggling with this problem of mental retardation, that it is only through extensive basic research into the prenatal and postnatal factors that are causative that we will make progress in acquiring the knowledge necessary to its prevention and control.

UNMET NEEDS OF THE RETARDED CHILD AND HIS PARENTS

Presented at the Governor's Conference on Mental Retardation by Maurice Mezoff, Executive Director, Massachusetts Association for Retarded Children, Inc.

In the preceeding sessions of this conference, this group discussed the many ramifications of the problem of providing services to the 140,000 mentally retarded children and adults, and their parents, now residing in Massachusetts. Discussion has focused upon the causes of mental retardation, the nature of the condition, and the programs and techniques by which both public and private agencies in Massachusetts have, up to this point, met the challenge for the care, treatment and training of mentally retarded persons.

Since the ultimate objective of the conference is to develop recommendations for the eventual accomplishment of a total program of services for the retarded, logical procedure demands that the next step be an examination of, and perhaps a clear-cut definition of, what constitutes a total service. This process involves the determination of the unmet needs of the retarded in relation to the existing services and the designing of specific recommendations for providing services that will fulfill these unmet needs.

The scope of this report, then, is to bring into focus the yet unmet needs from the viewpoint of the child and the parent and to present a description of services designed to make possible the framework on which to build such a total program.

The approach of this report is to present facts as they relate to these unmet needs and to raise certain questions, the answer to which might present a pattern by which both private and public agencies, working in harmony, might form the basis of this total program of services.

To set the stage for our examination of unmet needs and undeveloped services, it would be well for us to briefly scan the development of services throughout the Nation and in Massachusetts.

There have been interesting developments on a nationwide scale in that different States have tended to develop strength of service in different areas. One State may have a strong occupational training and rehabilitation program with no service to the preschool retarded child, while another State may concern itself almost wholly with recreation programs. This is probably due to the fact that—

(1) Programs for the retarded are underdeveloped and may still be considered as experimental. Any community program is considered a step forward.

(2) The type of service of a given State may reflect the interest of a strong parents' association or professional group and their perception of the immediate needs of the retarded.

From this pattern of development we have long since learned that a model of complete services is nonexistent.

In the eyes of the National Association for Retarded Children, the State of Massachusetts has one of the most highly developed systems of services to the retarded. Massachusetts provided residential care of the retarded over the past 110 years, dating from the opening of the Walter E. Fernald School in 1848. Special classes first made their appearance in Boston as early as 1898.

In more recent years, through legislative action initiated by the Special Commission on Mental Retardation and backed by the Massachusetts Association for Retarded Children, the State is providing diagnostic services, nursery clinic programs, recreational opportunities and a beginning has been made in the area of occupational training and job placement. The provision of these services has involved the Department of Mental Health and the Department of Education, the Massachusetts Rehabilitation Commission, and the relationship of these agencies to their local groups. The Departments of Public Health and Public Welfare have provided a great amount of service on an individual case basis.

At the same time, associations for retarded children, Catholic groups, public health nurses, family service agencies, private hospitals, as well as many other private agencies, along with practicing physicians, etc. are all providing some kind of treatment or care for the retarded.

If there is any marked characteristic of the growth of service to the retarded, it is that this development has taken place at a pace resembling more a change by revolution than by evolution. Each new service has pointed out the need for additional services.

While it is more desirable to proceed as quickly as possible, it is equally important that the direction taken in developing services will lead to the desired goals. It is vital, therefore, that future planning be done through an organized and systematic procedure. It is also essential that this planning be the joint effort of all of those departments of the State which will be called upon to assume responsibility for providing services in this total program.

To arrive at some concept of a total service to the retarded requires that we agree upon certain facts about the nature of mental retardation, and certain elements within our social service structure that make possible or impossible particular techniques for achieving this service.

First, is the realization of the accepted truth that in most instances the care, management, and training of the retarded is a shared responsibility between the parent and community, and that residential care of the retarded is not the beginning and ending of service. The care of most of the retarded is done in the home. Statistics of the Department of Mental Health indicate that with approximately 7,200 patients in State schools, this represents 5 percent of the retarded population, and that 95 percent of the retarded are cared for in the home. The care of the retarded in the community necessitates, therefore, the creation of new and specialized services within the community on the one hand, and the extension of and modification of existing services on the other.

Secondly, the retarded group is made up of individuals of a wide range of intellectual abilities and social skills. They are subject to behavior disorders, emotional problems, psychoses and neuroses, as are all people, and very often their disorders complicate the symptoms of retardation. The goals and services necessary for the severely retarded are quite different from those required for the moderately or mildly retarded.

Thirdly, because of the nature of mental retardation as a lifelong condition, there is a great need for continuity in service to the retarded. A meaningful service to the retarded implies continuing counseling and guidance as the retardate moves and develops through a chronological order of services. Herein lies the assumption that there is communication, cooperation, coordination between services.

Fourthly, there must be the realization of the interdependence and interrelatedness of services. For example, in the counseling process with parents of retarded children, the counselor, whether he be doctor, psychologist, or social worker, attempts first to achieve acceptance of the problem for the parent, but the next logical step makes it mandatory that this same counselor provide assistance to the parent by referring him or her to a facility which will provide the necessary care, education or training for the child. Good counseling becomes meaningless without these care and training opportunities.

On a broader level, this same interrelatedness of service has a cause and effect relationship between existing facilities. This has been markedly illustrated by the impact that the development of special education in the community has had upon the State school populations. All of our State school superintendents are now very much concerned with the fact that special education has resulted in a trend that has lowered considerably the IQ level of the State school populations. In the 20-year span between 1935 and 1955, the extremely retarded population (IQ under 20) increased from 13.9 percent of school population to 19.7 percent of school population, and the severely retarded (IQ 20-49) increased from 43.3 percent to 51.2 percent, or a total of 70.9 percent of total school populations presently is within the extremely or severely retarded range. This, in turn, has changed the staff needs, and program of the State schools.

Fifthly, in the development and growth of services, a very important factor is one of correct timing and coordination. To put it in the vernacular, one must be at the right place, at the right time, with the right ingredients in order to achieve a given aim. This involves the placement of services in areas where children are present, where facilities are possible, and where professional staff is available.

Compounding all of these complexities, are factors in the overall situation of a lack of trained personnel and the usual resistance to change embodied in our professional service. What is needed is a critical analysis along the following lines:

(A) A clear definition of the goals.

(B) Clear understanding of the needs to be served to reach the goals.

(C) Effectiveness of techniques for filling the needs. There tends to be general agreement among professional people as well as parents of retarded children that the goal we seek for the retarded child is that he or she be given every opportunity to achieve his or her fullest potential for leading a happy and useful life.

A total or comprehensive program of services is the technique by which these opportunities for reaching fullest potential may be realized within the individual. The best list of such services is contained within a document entitled "Proposals on a Federal Program of Action in 1956-57 for America's Mentally Retarded Children and Adults," submitted to the Honorable John E. Fogarty, Congressman from Rhode Island, by the National Association for Retarded Children.

They provide for—

1. A network of community diagnostic-treatment clinics with professional counseling for parents;

2. Home counselors to help parents in training the infant and child in the home;

3. Nursery classes, with normal children whenever possible; special nursery class and day-care centers for the more severely retarded;

4. Special education with improved vocational training for the "educable" child;

5. Special education with improved social training for the "trainable" child;

6. Vocational training centers and sheltered workshops, including personal adjustment training and terminal employment opportunities;

7. Community centers with recreational, social, and counseling facilities for the adolescent and adult retarded who are dependent and cannot be integrated into the facilities for normal people;

8. Integration of the "marginally independent" retarded in society, including vocational rehabilitation and selective placement in regular employment;

9. Dynamic, community-minded residence centers; and

10. Research and professional training.

Additional obvious needs are provisions for short-term care during the family crisis and in the case of the more severely retarded, short-term care is needed in order that the families might have some vacation from the constant pressure and tension created by this child in a family situation.

Halfway houses, as a means of integrating the former institutional retardate in the community.

One of the most perplexing and anxiety-producing problems faced by parents of the retarded is what will happen to the retardate after the death of the parent. This relates itself to the area of guardianship problems, and requires serious study and an early solution.

There is a need for a complete evaluation as to the criminal responsibilities of the defective delinquent and the development of care and treatment centers for these individuals.

Sometimes we become so concerned with the specialized needs of the retarded that we forget they also require the same kind of services which all of us need to lead a useful, happy, and productive life—adequate medical care, dental care, recreational opportunities, for example. And even here, the retarded require modified approaches for these usual services. Connected with medical care for the retarded is possible use of drug therapy. For dental care there is the need possibly of dentistry performed while the patient is under total anesthesia. The application of corrective measures for the improvement of speech, hearing, and sight—parenthetically, I would like to add that current research being conducted at the University of Texas gives indication that the correction of some of these physical deficiencies has led to an improvement in intellectual performance—in some cases raising the IQ level of the retarded child from the trainable to the educable classification.

All of these extensions of usual types of care point to the need for specialized professional training and cooperation among disciplines to recognize and accept their responsibilities for fulfilling these exceptional needs. While time does not permit a complete analysis of these needs, it is important that further consideration be given many of the items.

1. A network of community diagnostic-treatment clinics with professional counseling for parents

The term "network" implies geographic distribution of diagnostic treatment. As of the present time, opportunity for diagnosis is available in the public agency field through outpatient services provided by the State schools. Some diagnostic service is available through mental health centers. Diagnosis occurs mostly, however, in the office of the general practitioner or pediatrician, or in a private hospital. Most of the clinic services, however, are located within the eastern region of the State.

Good diagnosis for the retarded child cannot be a one-time process, but must be a continuing program, accompanied by periodic evaluation of progress—or lack of it. The fact that the symptom of retardation can be both simulated and stimulated by overtones of emotional factors, physical defects, and limited opportunities for socialization, emphasized the need for this periodic testing of the individual.

Directly connected with the diagnosis and evaluation process is the problem of parent counseling. The very fact that the parent brings the child for a diagnosis is indication of a premonition on his part that all is not well—the confirmation of the fact of retardation by diagnosis can have a shattering effect if the findings are not presented skillfully. And in this instance one might well sacrifice objectivity for compassion—technical terminology for clarity in explanation. Counseling, while pointing out the limitations of the child, should also assess his positive attributes and potential for achievement through education or training.

In the development of diagnostic services, the question of the effectiveness of the specialized clinic versus the general clinic requires serious consideration. Adequate counseling services require the greatest amount of knowledge as to available facilities and effectiveness of training programs for particular types of mental retardation. In this area, also, there is a great need for more effective

techniques in evaluation of mentally retarded children. In addition, there is needed clearer definition of the role that each of the disciplines play in jointly planning for the retarded so that, with maximum knowledge about the child, they can together produce the most effective plan for the care and treatment of the child.

2. *Home counselors to help parents in training the infant and child in the home*

In Massachusetts, this kind of service is extremely limited and fairly well confined to the individual efforts of public health nurses, the advice and counsel of the pediatrician or general practitioner, and in some instances a psychiatrist. There is no organized program now meeting this crucial need. Doctors and other professional disciplines have long recognized the need for early diagnosis so that proper care and training might begin at the earliest possible moment. Mothers need a great deal of help in something as simple as toilet training the child.

Within this area is raised the question of whether or not there is a need for legislation which would make it mandatory for doctors and hospitals to report, as they do in other diseases, the birth of retarded children. It would then become incumbent upon the public health nurse to make periodic visits to help in the care and training of the child in the home. This also relates itself to helping to prevent immediate placement in an institution of newborn children. It also provides the opportunity for evaluating the impact of the retarded child on family life so that counseling can be provided for heading off difficulties.

3. *Nursery classes, with normal children whenever possible; special nursery classes and day-care centers for the more severely retarded*

In this area Massachusetts has forged well ahead, in that its nursery clinic program is functioning at the present time, not only in providing nursery programs but in terms of evaluation services, speech therapy, and medical care when needed.

Day-care centers in the communities are nonexistent for the retarded. One of the great needs as of the present moment is for some type of service for the atypical child who through behavior disorders, severe retardation, hyperactivity, or lack of special education opportunity is given no service whatsoever. Day-care programs provide the opportunity for care of these severely retarded in the community on a shared basis between the service and parents and reduces the need for institutionalization. For those with emotional problems, it should provide the opportunity for psychiatric treatment, so that the child might be prepared to enter other services. For the emotionally disturbed, also, there is need in these programs for counseling with parents to adjust the home environment so that the child might better respond to treatment. Here, we might raise the question as to whether or not day-care centers are a normal extension of State school services or an independent function.

4. *Special education with improved vocational training for the "educable" child*

In Massachusetts special education is a highly developed service for the educable child. There is great need, however, for evaluation of the role of the schools in the preparation of the educable for employment, the responsibility of education in job placement, and the need for personnel in the area of "followup."

Within this area, also, is the need for definition of the respective roles of both education and the rehabilitation commission. Is this a joint responsibility or is there a need for clearly defined areas of responsibility?

5. *Special education with improved social training for the "trainable" child*

At the present time there is required here clearer definition of the goals for the trainable child, the question of whether or not facilities for the trainable child should be separate and apart from the school systems or whether they should be further integrated into school systems. The whole area of activity for the postschool trainable child needs a great deal of study and exploration.

6. *Vocational training centers and sheltered workshops, including personal adjustment training and terminal employment*

This relates itself to our fourth and fifth points. There is need here for the creation of such services and a clear understanding as to the responsibilities of education and the rehabilitation commission in fulfilling these needs. Exploration is necessary as to whether or not such centers should be residential to accommodate retardates from different areas of the State or whether or not these

services should be developed in small units with larger geographic spread. Or, are sheltered workshops the basic responsibility of private agencies?

7. *Community centers with recreational, social, and counseling facilities for the adolescent and adult retarded who are dependent and cannot be integrated into the facilities for normal people*

This type of opportunity for recreation and socialization has been successfully operated in Great Britain for a number of years. American community life offers every opportunity for success in the achievement of such services. YMCA's, Boys Clubs, and other community group work centers could be induced to assume such responsibilities in cooperation with local associations for retarded children.

8. *Integration of the "marginally independent" retarded in society, including vocational rehabilitation and selective placement in regular employment*

This process of integration takes place around us day by day. The marginally independent group, in followup studies of special class graduates in the Fitchburg area, reveal interesting patterns of this integration. These young people find jobs, own cars, marry, and raise families. These same studies point out both the successes and happiness achieved as well as their trials and tribulations. Girls tend to keep better homes and give better care to their children than did other parents. Job placement is achieved almost exclusively through family contacts (about 85 percent) with almost no use of public or private agency help. A marked characteristic is the frequency of job changing over relatively short periods of time.

Here, again, is indicated the need for guidance and counseling as to occupational goals, training, and techniques in finding jobs. There is need for interpretation to employers relative to promotion—whether it be desirable or undesirable in the case of the individual involved. Need also exists for continued contact on the part of the retarded with a counselor for encouragement, after failures, to try and try again.

Our Massachusetts Rehabilitation Commission has moved rapidly and well into this area of service. Much remains to be done.

9. *Dynamic, community-minded residence centers or institutions*

The general trend in Massachusetts has been to relate as closely as possible the State school and the community. Limits have been proscribed by geographic location. As of the present time, our State schools provide not only 24-hour patient care and training opportunities for those in residence but also serve the community through outpatient, diagnostic clinics, day occupational training programs, and now legislative action has provided money for personnel for day recreation programs. In addition, our State school superintendents have encouraged staffs to educate the general public about mental retardation and the institution through musical and other programs presented before civic groups, PTA's, and others.

Wherever possible, encouragement has been given to the use of State schools for training purposes in conjunction with neighboring hospitals and universities. At this time, it would be most desirable to investigate the possibility of further use of our State institutions for training purposes by universities in the non-medical disciplines. What is needed in both the medical and nonmedical fields is an aggressive policy of recruitment and the development of a climate and of facilities within the State school that would provide opportunities for good training and genuine research.

Long-range planning for State schools in Massachusetts might well be the subject matter of a similar conference in the near future. Questions need to be answered about future building programs, relative to location and size of unit, type of staff and equipment needed to serve the changing populations, how these may be related to hospitals and universities, and the possible development of the cottage system, and the development of further colony-type installations for serving the retarded. Recent trends toward inservice training need to be encouraged and explained.

From the viewpoint of the parent, the economic strain of rising costs of keeping children in the State schools is becoming an alarming problem. There is great need for setting a maximum and reasonable fee charge. The question of whether or not parents should have financial responsibility after the retardate has reached the age of 21 needs to be examined. In the case of some retardates who perform services at the State school, consideration should be given to com-

pensation for the services performed. The inservice training program for patients at Monson State Hospital should be examined for possible application at other State schools.

None of these ideas will be new concepts, but have been topics of discussion of our leading professional workers in this field over a number of years. In some areas of the country these concepts have become a reality and a means of service to the retarded and the community.

10. Research and professional training

Massachusetts has been one of the leading States in the area of medical research and has taken advantage of available funds from Federal and private sources to implement its programs. While it is not our intention to minimize the importance of medical research as it relates to the prevention of mental retardation, what is needed in Massachusetts is greater stress in the nonmedical areas to provide new knowledge about techniques in the training, care, and management of the retarded. While we are blessed in Massachusetts with glittering constellations of institutions of higher learning who specialize in those particular disciplines which can push back the frontiers of our ignorance in all of these areas, little or no research relating to the particular problems of retardation are conducted at these universities. What is needed is a definite program designed specifically to encourage these universities to seek available funds for the development of full-scale, long-range research programs.

There is great need for the development of new evaluation techniques by psychologists. Social workers need to know about the impact on family life of the problem of retardation. Even at the simple level of examining the waiting list at State schools to determine needed services, research could be carried out. Only if we accept the challenge of research can we hope to make progress. While we may be forced into geographic isolation because of the locations of our State schools, the failure to develop research projects would be the result of our own intellectual isolation.

In the professional training area, Massachusetts enjoys the dubious distinction of having trained more people for service in other States than any other university center in the country. This relates itself to the unrealistic salary scale of State employees at all levels. Actually, salary scales are far below those paid for equivalent positions by either private or Federal agencies. This has tended to make transient those professional workers trained in Massachusetts. The desire on the part of trained professional workers to properly feed, clothe, and educate their families need not be considered as a lack of dedication or idealism. Our continued failure to face the reality of substandard pay scales must inevitably lead to the lowering of standards of services.

Over and above this, there needs to be consultation with our university administrators for the inclusion of information regarding mental retardation within the curriculum of these training institutions. We must discuss whether or not separate courses ought to be encouraged or whether mental retardation should become a normal part of any given curriculum in the training of professional workers whose skills are required in serving the retarded. There needs to be discussion about the most effective techniques to be used in getting information about mental retardation to those workers already trained and now functioning on jobs throughout the Commonwealth.

In summary, I would like to point out that in this dissertation I have merely shown what, from our experience, are the unmet needs which must be fulfilled if retarded children and their families are to achieve the status of first-class citizenship which is the inalienable right of us all.

I have posed the questions and, in setting forth some of the needs, I believe I have given some indication of the agencies which might bring their skills and forces to bear in attempting to meet them.

The dramatic progress which has been taking place in the field of mental retardation is directly proportionate to the interest which has been stimulated in professional workers. As parents have articulated their problems, dedicated leaders in the professions of medicine, education, psychology, social work, rehabilitation, and other areas have come forward to help in seeking solutions.

In reality, our only regret—as manifested by the theme of this conference—is that programs have developed unilaterally within disciplines.

Despite a healthy year-to-year progress in Massachusetts in specific services to the retarded, there are increasing signs that there is great need for organization and careful planning in developing further services. Further progress is dependent on—

1. A determination of the exact needs of the retarded.
2. Evaluation of existing facilities and services in relation to these needs.
3. Coordination, cooperation, and communication between all professional disciplines.
4. Communication and coordination between public and between private and public agencies.
5. Careful planning with the most efficient use of existing facilities.
6. Stimulation of interest in the problem among professional people.
7. Increased opportunities for training workers in this field.

The concept of coordination in this field is actually a call for statesmanship; it requires that agencies which to date have done little in the field of mental retardation assume more responsibilities in the areas in which they can best provide services—it requires also that agencies which have been traditionally responsible for some areas of care (because the needs were not being fulfilled elsewhere) relinquish the reins and responsibilities for implementation of these programs to agencies better qualified by training and staff to carry them out.

I believe that our meeting together over the past few days is singularly significant, not because this group has devoted its time, energies, and intellect to resolving problems as they relate to the mentally retarded, but because it may set a pattern of cooperative action among professional workers which will make it possible in the future to seek solutions to equally difficult problems which affect our people and our community. Our meeting over the past few days means that we have accepted the challenge, and the benefits derived from our joint thinking will mean a happier, more fruitful life for all of our citizens.

RESOLUTIONS—GOVERNOR'S CONFERENCE ON MENTAL RETARDATION, MAY 26-27, 1959

Resolution No. 1: This committee recommends that His Excellency, the Governor, take whatever steps are necessary to create an interdepartmental committee composed of all departments concerned with the mentally retarded, headed by the commissioners or their representatives.

Resolution No. 2: That there be created a Governor's Conference on Mental Retardation composed of public and invited private agencies which will meet every year for the purpose of overall planning in the field of mental retardation, the expenses of which will be met by the various departments and agencies. This annual conference is to be called by the Governor.

Resolution No. 3: It is recommended that the chairman of such an interdepartmental committee shall report to any legislative commission on mental retardation that shall exist.

Resolution No. 4: It is recommended that the Governor shall use his office to assure widespread publication and distribution of the report of this conference.

WORKSHOP No. 1

TEAM APPROACH OF THE DIAGNOSIS, EVALUATION, AND PLANNING FOR THE RETARDED CHILD

Workshop leader: B. R. Hutcheson, M.D.

The following resolutions and recommendations were formulated:

1. For those children placed in special class, the practice should be encouraged of adequate and appropriate followup for both child and parent.
2. The responsibility for interpreting to parents that they have a mentally retarded child should rest on the findings which utilize the team approach for diagnosis. Such a team should be composed of at least a physician, psychologist, and social worker.
3. The practice of diagnosing and evaluating retarded children on the basis of an IQ score alone should be discouraged. In addition, it is recommended that a psychometric examination should not be considered the equivalent of a psychological examination.
4. Every retarded (or suspected retarded) child is entitled to comprehensive medical, social, and psychological evaluation before entering school.
5. It is recommended that in medical school curriculums there be provision for training physicians in the various diagnostic aspects presented by the re-

tarded child. In the training of pediatricians, psychiatrists, and child psychiatrists there should be provided the experience of working with, diagnosing, and treating the mentally retarded.

WORKSHOP No. 2

RECOMMENDATIONS OF WORKSHOP ON PLANNING FOR THE PRESCHOOL RETARDED CHILD

Workshop leader: Lewis B. Klebanoff, Ph. D., S.M. in hygiene.

1. Strengthening of child health and welfare services throughout the State will aid the retarded and should be encouraged. This includes—

- A. The DCG.
- B. The local welfare—ADC.
- C. The well-child conference.
- D. Day care center services, etc.

2. Working relationships should be established between the nursery centers and day and residential schools and other community facilities to help in developing a continuing life plan appropriate to each child and his family.

3. Increasing emphasis should be placed in early case finding with particular reference to special risk situations, such as premature births that are routinely known to health agencies.

4. Provision should be made for expanding and coordination of clinical services to existing nursery centers and to geographical areas of the Commonwealth where there are no services.

5. Provision should be made for encouraging the colleges and universities to include training programs for teachers of the preschool retarded.

6. Provision should be made for personnel to provide aid in the home to the mother in improving the self-help skills of the child under 3 years of age.

WORKSHOP No. 3

MEETING THE NEEDS OF THE SCHOOL-AGE RETARDED CHILD

Workshop leader: Philip G. Cashman, Ed. D.

I herewith submit to you the resolutions recommended by Workshop No. 3:

1. To develop a more comprehensive program for the early and accurate identification of mentally retarded children.

2. To develop a common understanding between the teacher and members of other disciplines concerned with the mentally retarded child.

3. To develop a team approach for interdepartmental counseling. The teacher of the mentally retarded should play an important role in this program.

4. To enrich the training of the special class teacher by including additional training in mental hygiene, guidance, and occupational information.

5. To provide training facilities and personnel at all State teacher colleges for the purpose of aiding prospective regular classroom teachers to identify mentally retarded children at an early age.

6. To provide both special class teachers and regular class teachers with in-service training programs for the better understanding of the mentally retarded child.

7. To provide more adequate guidance, occupational training, placement and followup services at the local and State levels.

8. To stimulate grassroots conferences to submit proposals and resolutions which may be considered at State conventions.

9. The establishment of better lines of communication among all agencies concerned with the mentally retarded. To organize an effective program of public relationships.

10. To develop additional avenues of interdepartmental cooperation for the better identification, referral, and treatment of mentally retarded children. Such a program should spell out the responsibility of various agencies concerned with the mentally retarded.

11. That all children referred by classroom teachers for examination under the provisions of General Laws, chapter 71, section 46, and the regulations pur-

suant thereto, shall be given such examination at the earliest possible moment.

12. That the team approach to the diagnosis and treatment of the mentally retarded be encouraged.

13. That copies of the report of this panel be summarized and sent to participating members.

WORKSHOP No. 4

THE PROBLEM OF THE RETARDED ADULT: HABILITATION AND REHABILITATION

Workshop leader : Francis A. Harding.

Resolutions voted by the participants of workshop 4 under the leadership of Commissioner Harding :

1. To make a study of retarded individuals to determine job potential while they are still in school.

2. To provide proper occupational training, guidance, and job placement to meet the needs of the mentally retarded.

3. To develop an orientation program including employers in order that they may understand occupational potentials of the retarded.

4. To place greater emphasis on community responsibility in providing occupational opportunities for the retarded.

5. To pool resources of the community to provide an adequate program and to assist in the occupational training of the retarded.

6. To expand facilities for exploring job opportunities within the community.

7. To make mandatory present legal provisions for regional occupational training classes for retarded children.

8. To establish occupational training centers in Massachusetts for vocational and social rehabilitation for men and women. (Halfway Houses, etc.)

9. To encourage passage of legislation to establish a program for "independent living" in Massachusetts for mentally retarded individuals who lack occupational rehabilitation potential.

10. To provide a continuous followup program on local and State levels to develop and encourage a cooperative system between various agencies which deal with the retarded child within the city and the State.

11. To develop and encourage a cooperative system between the various agencies which deal with the retarded within city and State in all phases of adjustment.

WORKSHOP No. 5

THE ROLE OF THE RESIDENTIAL CENTER IN COMMUNITY SERVICE TO THE RETARDED

Workshop leader : Karl V. Quinn, M.D.

Resolutions :

1. A defective delinquent person should be sent to a reception center, such as Lancaster or the youth service board, for a certain period and then be transferred to a special security unit at a State school.

2. That State schools should have the facilities to care for any mentally deficient child with any type of emotional or delinquent problems.

3. That State schools be equipped to give training to prospective personnel in the communities.

4. That State schools should be reduced in size and new ones located so that they could be of more use to more communities with prospect of being able to employ adequate personnel from these communities.

5. That volunteer and parent associations be strengthened and supported.

6. That a greater latitude of visiting in State schools be recommended for better public relations.

7. That added efforts be made for greater cooperation with the universities and centers such as Massachusetts General Hospital.

8. That efforts be made to reduce the isolation of people in the western part of the State from community and other services, other than those of the Belchertown and Monson areas.

9. That children with an IQ between 0.75 and 0.90 be in a program for placement as part-time workers in institutions at a small but adequate salary.

10. That further collaboration is desired between mental health centers, State schools, and school psychologists for increased services to mentally retarded children who are living in the community.

11. That the vocational rehabilitation commission and State schools develop more and greater cooperative programs.

WORKSHOP No. 6

SOCIAL ADJUSTMENT PROBLEMS OF THE RETARDED

Workshop leader: Francis J. Kelly.

This workshop recognized that social adjustment is determined by emotional as well as intellectual capabilities; it also recognized that the adjustment of these persons to society is determined to a great extent by society's adjustment to them.

Utilizing this frame of reference, our panel and group discussed and agreed upon three basic premises upon which we predicated our discussion and the resolutions it produced.

BASIC PREMISES

We must not lose sight of the human dignity and worth of the retarded. Because an individual is intellectually limited, it does not make him less human or reduce his spiritual value. We must see the person in his totality, not emphasize his weaknesses without bolstering his strength.

The retarded have emotional needs and are as sensitive to deprivation and lack of affection as the normal group. They are as susceptible to the same emotionally crippling illnesses as they are to the same physical illnesses—perhaps more so, since the normal person can utilize intellectual abilities to mobilize defense systems to ward off unpleasant life experiences, while the retarded does not have adequate intellectual resources to call upon.

Principles of good positive mental hygiene are as applicable to this special group as they are to the general population. The establishment of positive, meaningful relationships in early life with the parents, and later in the school and community, is of vital importance.

We feel that we can categorize our resolutions into the three main areas of personal interaction in which we all most participate. These areas are the home, the school, and the community.

RESOLUTIONS OF WORKSHOP

A. The home

1. Whenever possible, the retarded person should be maintained in his own home. Public assistance benefits should be provided, if necessary, to maintain him in his home, even though the family may not be eligible for or receiving other public assistance.

This resolution applies only where the person's presence in the home is not harmful to him or the family.

2. If it is necessary to remove a retarded child from his home, first consideration for placement should be in a foster home. Institutionalization may be the easiest but is not always the best placement for the child.

3. Within the family structure, parents and siblings should be urged to accept the retarded person where he is and how he is. Overindulgence and overprotection can be as damaging as deprivation and neglect. The retardee should be accepted with his limitations, as an individual, with the understanding that he will react to either extreme of care or neglect as normal children will.

4. Education of parents should be offered to aid in the early recognition of retardation, and in this way avoid the trauma which might occur prior to their realization of the limitations of the child.

5. The expansion of group parental counseling under the direction of trained group therapists should be encouraged; also, support of programs whereby parents of these children may meet and discuss their difficulties with one another for mutual benefit, information, and support.

B. The school

1. The school should offer every child an opportunity for success, despite his limitations. This will involve a reexamination of our present concept of and emphasis upon academic performance. Diagnosis of retardation should be the result of a complete psychological examination by a well-trained person as

opposed to that based on a numerical score obtained on a psychometric examination.

2. We strongly urge the retention of children in school beyond the compulsory age of 16 if any benefit can be derived from this retention. Conversely, for those children who have attained maximum benefit prior to their 16th birthday, arrangements should be made for withdrawal. The child turned out too soon, or retained too long, may well discharge the feelings resulting from the inherent frustration in unacceptable behavior.

3. We favor improved communication with teachers to enable them to recognize and understand these children, and assist in the handling of the problem they represent.

C. The community

1. Education of the public through use of existing media to enable them to better accept the retarded, inform them as to causes, and help remove the stigma attached to both the retarded and his family still found today.

2. Education of the professional people having contact with the retarded or their families. The program should include not only medical people but the clergy, school, the police, courts, etc., who may use this information to better meet the problem.

3. Formation of social and recreational groups of retarded persons, particularly in adolescence and postadolescence, to provide social interaction under the supervision of trained adults. This will provide an opportunity to develop social skills, and existing services such as YMCA, boys' clubs, girls' clubs, CYO, settlement houses, etc., may be utilized.

4. When a retarded person acts out antisocially and is brought before the courts, expert diagnostic assistance to the court in making the differential disposition of whether to treat the person as a retarded or defective, or as a delinquent or criminal.

5. Establishment of a new, separate and adequately staffed and programed facility within the existing framework of the State schools, for the defective delinquent children who, due to their impulsiveness, hyperaggressiveness, and severe retardation, cannot be handled properly in existing institutions.

6. Restudy of the existing defective delinquent legislation by a joint commission, with representatives of all professional disciplines interested in the problems such as law, psychiatry, education, psychology, etc. We feel that consideration should be given to the fact that the defective person now has to commit a dangerous act before legal steps may be taken. If, and always bearing in mind the individual's constitutional rights, expert evidence was presented that the potential for such action was present and the imminence of the act itself was guaranteed, could legislation be amended so that the individual could be removed from the community before he harms someone or himself?

Mr. GIAIMO. The next witness is Michael F. Marinkowski, executive director of the TB and Health Association, Burlington, Vt.

STATEMENT OF MICHAEL F. MARINKOWSKI, EXECUTIVE DIRECTOR, TB AND HEALTH ASSOCIATION, BURLINGTON, VT.

Mr. MARINKOWSKI. I would like to withdraw as a witness in view of the fact that suggestions are going to be brought up by the workshop in which I participated.

Mr. GIAIMO. Thank you very much.

Fred D. Knittle, director of development, Clarke School for Deaf, Northampton, Mass., is our next witness.

You may proceed, sir.

STATEMENT OF FRED D. KNITTLE, DIRECTOR OF DEVELOPMENT, CLARKE SCHOOL FOR DEAF, NORTHAMPTON, MASS.

Mr. KNITTLE. Mr. Elliott, members of the committee, it is a distinct pleasure to appear here today to read into the record of this hearing

a few important facts pertaining to the critical shortage of classroom teachers of the deaf.

My relationship to this special field of education has been of relatively short duration. In replacing Mr. Evan Johnston as director of development of the Clarke School for the Deaf, I have assumed his role as a spokesman for the Conference of Executives of American Schools for the Deaf. I have become increasingly aware of this growing need and can appreciate the problems faced by the leaders in this field.

In the few short months since House Joint Resolution 494 and its counterparts were introduced, we have received numerous letters from educators, parents, and friends, from all over the United States, stating their great interest in this bill and their sincere desire to see its early passage. They join with me in support of this resolution.

No one knows exactly how many people in the United States are deaf. It has been estimated that as many as 15 million people have some loss of hearing and that 8 million of these suffer a loss sufficient to warrant the use of a hearing aid.

Many people with hearing losses can be helped by medical, surgical, or mechanical means to regain their hearing, or at least to compensate for it.

There are, however, from 170,000 to 200,000 people who are truly deaf; that is, they cannot recognize sound as we know it.

Only through intensive training in a highly specialized program and in the use of the small amount of residual hearing they may have can they compensate for this loss.

Modern medicine has done much to overcome many disabilities in children. But, at the present time, education, not medicine, provides the major hope for the deaf child.

There are today nearly 30,000 children enrolled in 365 schools and classes for the deaf in the United States. Most of them have one thing in common: they became deaf before they had acquired language. A deaf child may see a person's lips move, but he cannot relate that movement to sound, nor can he relate it to the written word or visible object.

He has no language at all. To put the components of language into a meaningful relationship is the primary mission of the teacher in a school for the deaf. For the deaf child, this teacher is the bridge between his world of silence and the world of sound around him. To a considerable degree, the success with which he reconciles the two worlds together depends on the skill and patience of his teacher.

For a number of years there has been an acute shortage of trained academic classroom teachers of the deaf. The situation has grown progressively worse as the number of qualified teachers of the deaf being graduated each year fails to keep pace with the growing demands.

Every administrator of special schools or classes for the deaf in the United States is being confronted with the problem of increased enrollment and a dwindling supply of professionally trained teachers of the deaf.

This year, a survey of the need for classroom teachers of the deaf has been made by Mr. Johnston, my predecessor, and Dr. D. Robert Frisina, director of the Hearing and Speech Center of Gallaudet College in Washington, D.C.

I would like to quote several paragraphs from this study and to comment upon some of its findings:

A number of factors apparently have contributed toward making the teacher shortage critical. The recruitment of teachers in the field of general education has not kept abreast of the needs. Undoubtedly, the need for special teachers of the deaf reflects in part the teacher needs of the Nation as a whole.

Although the percentage of deaf among the general population of the United States probably is not changing, the actual number of deaf children is likely to be increasing as a result of the increase in the overall population of the United States. New medical discoveries and techniques which tend to decrease the mortality rate also may be contributing to the increase in the number of deaf children who otherwise might not have lived prior to such medical advancements. Earlier detection of problems in hearing has resulted in initiating special training at a younger age.

Classes for the multiple handicapped deaf also are being established and require additional teachers. A considerable number of teachers of the deaf are employed in speech and hearing clinics, the number of which has grown rapidly since 1945.

Finally, the supply of classroom teachers of the deaf has scarcely been sufficient to meet the needs brought about by retirement from the profession for one reason or another.

The study was undertaken to determine the need for trained academic classroom teachers of the deaf. In order to approximate the supply-demand ratio, some 365 administrators in special schools and classes for deaf children in the United States were contacted. Of this number, 233 replied to specific questions designed to reflect the overall need for teachers during the academic year 1959-60, to provide information concerning past years, and a general question pertaining to the future.

Of the 233 educational facilities responding, they represented 5 categories:

- Public residential schools;
- Public day classes;
- Public day schools;
- Denomination and private residential schools;
- Denominational and private day classes.

The study points out that 516 trained classroom teachers of the deaf were needed in the United States during the 1958-59 school year. To meet this demand, only 118 teachers were graduated from the 22 approved training centers, leaving 111 educational facilities, about 48 percent; unable to fill their needs.

The year 1959-60 holds no great promise. In June of 1959, 127 teachers in training graduated, but 15 of these were foreign students, and will teach in foreign lands. This left 112 teachers available to fill 511 vacancies in the United States.

Prior to June of 1959, six training centers indicated no trainees enrolled at all.

The future holds an even greater challenge. Sixty-eight percent of the 233 responding indicated that they would require an increase in the number of trained classroom teachers of the deaf due to future expansion. Although 3 more training centers have been approved and the number of teachers in training to be graduated at

the end of this school year has increased to 161, we are far from meeting our teacher requirements. Five centers have no teachers in training even now.

What, then, is the alternative?

The problem can be met several ways.

First, classes can be, and are, expanded beyond a good teacher-student ratio. Because of the type of almost individualized instruction needed by these young people, this is not available.

Another alternative is to limit the enrollment of deaf children. With the growing number of deaf children requiring this special education, this would only compound an already serious problem.

Another possibility, and I'm afraid one that is being practiced because of necessity, is to employ teachers who are unqualified in this field, and to provide them with inservice training. Because of the heavy load on present teachers, this also is quite impractical.

The only reasonable answer is to provide such an incentive as to attract many more high caliber young people to this special educational field.

The financial assistance included in this resolution would be a great help in providing incentive to those who normally would not enter the profession because of economic limitation. Through this, and by increasing our own recruiting activities, this problem can be eased.

It was not too many years ago that a deaf child, mute only because he was unable to hear, was forced to walk a path of loneliness, isolation, and many times ridicule. But today, providing with specialized education by dedicated and responsible teachers, this same child can become a self-supported citizen making an effective contribution to a hearing world.

I urge you to help us meet this growing demand for academic classroom teachers of the deaf by favorable action on House Joint Resolution 494.

I submit also the study by Dr. Frisina and Mr. Johnston.

Mr. GLAIMO. Without objection, the papers will be made a part of the record.

(The material referred to follows:)

[Study by Dr. D. Robert Frisina and Mr. Evan V. Johnston]

A STUDY OF THE NEED FOR ACADEMIC CLASSROOM TEACHERS OF THE DEAF IN THE UNITED STATES

For some time administrators of special schools and classes for the deaf in the United States have been aware of an acute shortage of trained academic classroom teachers of the deaf. The number of professionally trained teachers of the deaf being graduated each year has failed to keep pace with the demand.

A number of factors apparently have contributed toward making the teacher shortage critical. The recruitment of teachers in the field of general education has not kept abreast of the needs. Undoubtedly, the need for special teachers of the deaf reflects in part the teacher needs of the Nation as a whole. Although the percentage of deaf among the general population of the United States probably is not changing, the actual number of deaf children is likely to be increasing as a result of the increase in the overall population of the United States. New medical discoveries and techniques which tend to decrease the mortality rate also may be contributing to the increase in the number of deaf children who otherwise might not have lived prior to such medical advancements. Earlier detection of problems in hearing has resulted in initiating special training at a younger age. Testing and treatment of preschool children with impaired hear-

ing were emphasized approximately 15 or 20 years ago, and at present 2,892¹ children under the age of 6 are enrolled in schools and classes for the deaf. If a pupil-teacher ratio of 6 to 1 were attempted, this group alone at the present time would require approximately 482 additional teachers above the needs of the schools and classes prior to the emphasis on preschool programs. Classes for the multiple handicapped deaf also are being established and require additional teachers. A considerable number of teachers of the deaf are employed in speech and hearing clinics, the number of which has grown rapidly since 1945. Finally, the supply of classroom teachers of the deaf has scarcely been sufficient to meet the needs brought about by retirements from the profession for one reason or another. The most recent figures concerning the number of professionally trained teachers of the deaf becoming available June 1959 is reflected in the January 1959 issue of the *American Annals of the Deaf*² and is reportedly 127. Among these 127 are approximately 15 foreign students who will not be available to teach in the United States.

The present study was undertaken to determine more closely the magnitude of the need for trained academic classroom teachers of the deaf. In order to approximate the supply-demand ratio, some 365 administrators in special schools and classes for deaf children in the United States were contacted. Of this number, 233 replied to specific questions designed to reflect the overall need for teachers during the academic year 1959-60, to provide information concerning past years, and a general question pertaining to the future. The specific questions asked each administrator were:

- (1) How many new trained classroom teachers of the deaf will you need next year (1959-60)?
- (2) How many new trained classroom teachers of the deaf did you need last year (1958-59)?
- (3) Were you able to fill this need?
- (4) What do you estimate has been your average yearly need for additional or replacement classroom teachers for the past 10 years?
- (5) Will your present needs increase through expansion?

The above data were analyzed with the 233 educational facilities for the deaf considered in five categories:

- (1) Public residential schools.
- (2) Public day classes.
- (3) Public day schools.
- (4) Denominational and private residential schools.
- (5) Denominational and private day classes.

Information pertaining to the needs for teachers during the 1959-60 academic year and the average number required for each type of educational facility is summarized in table I. Ninety-six percent of the administrators in public residential schools responded to the inquiry. These 69 schools reported a need for 256 teachers or an average of 3.71 per school. Fifty-five percent of the public day classes responded and indicated a need for 153 teachers. Of the 124 public day classes providing this information, each needed an average of 1.23 teachers. All of the 10 public day schools responded and collectively indicated a need for 44 teachers, which is an average of 4.40 teachers per school. Thirteen denominational and private residential schools reported a need for 33 teachers, an average of 2.53 for each school. Forty-two percent of the denominational and private day schools and classes suggested a need of 25 teachers, an average of 1.47 each. The totals indicate that 233 (64 percent) of the 365 educational facilities responded. As a group, this indicated a need of 511 teachers for 1959-60. This represents 2.19 teachers for each educational facility.

¹ The *American Annals of the Deaf*, vol. 104, No. 1, January 1959, p. 154.

² The *American Annals of the Deaf*, vol. 104, No. 1, January 1959, pp. 108-110.

TABLE I.—*Academic classroom teachers of the deaf: Reported needs for 1959-60*

Type of educational facility	Total number reportedly in the United States ¹	Number responded to inquiry	Percent of total responding	Number of teachers needed, 1959-60	Average number of teachers per educational facility needed
Public residential school.....	72	69	96	256	3.71
Public day class.....	227	124	55	153	1.23
Public day school.....	10	10	100	44	4.40
Denominational and private residential school.....	16	13	81	33	2.53
Denominational and private day school and class.....	40	17	42	25	1.47
Total.....	365	233	64	511	2.19

¹ See the American Annals of the Deaf, vol. 104, No. 1, January 1959, pp. 111-149.

Information concerning the number of trained academic classroom teachers of the deaf required during the 1958-59 school year is presented in table II. In addition to the average number of teachers required in each educational facility, the percentage of schools and classes not able to fill their needs during 1958-59 is included. The reports from 233 educational facilities indicated that 516 classroom teacher were needed. This represents an average of 2.21 teachers for each. One hundred and eleven of the reporting 233 or 48 percent of these educational facilities were unable to fill their needs during that year.

TABLE II.—*Number of trained academic classroom teachers of the deaf required, 1958-59*

Type educational facility	Number reporting	Number of teachers required, 1958-59	Average number of teachers required per educational facility	Number of educational facilities not able to fill needs, 1958-59	Percent educational facilities not able to fill needs, 1958-59
Public residential school.....	69	259	3.75	38	55
Public day class.....	124	158	1.27	54	44
Public day school.....	10	44	4.40	7	70
Denominational and private residence school.....	13	34	2.62	4	31
Denominational and private day school and class.....	17	21	1.24	8	47
Total.....	233	516	2.21	111	48

Table III summarizes the average annual additional and replacement needs of academic classroom teachers of the deaf during the past 10 years and indications of expansion in the future. The average annual teacher needs during the past 10 years in public residential schools has been 3.06. Seventy-four percent of such schools indicated that their needs would increase in the future. Ninety public day classes provided data which indicated a need for an average of 1.56 teachers per annum during the past 10 years. Sixty percent of these classes indicated increasing needs for the future. The public day schools have indicated an average of 3.5 teachers needed annually during the past 10 years, and 90 percent indicated increasing needs for the future. Denominational and private residential schools suggested a need for 2.3 teachers per year, and 77 percent indicated that their requirements would increase. The average annual need for teachers in denominational and private day schools and classes during the 10 preceding years was 1.46. Eighty-eight percent of such educational facilities indicated increasing needs in the future. The total number of educational facilities indicating annual needs for the past 10 years was 186, and the average annual need per facility was 2.2. Sixty-eight percent of the total respondents (233) indicated that they would require an increase in the number of trained academic classroom teachers of the deaf due to future expansion.

TABLE III.—Average annual additional and replacement needs of academic classroom teachers of the deaf during the past 10 years and indications of expansion in the future

Type educational facility	Number reporting	Number indicating annual needs past 10 years	Average annual needs past 10 years	Number indicating increasing needs in future	Percent indicating increasing needs in future
Public residential school.....	69	63	3.06	51	74
Public day class.....	124	90	1.56	74	60
Public day school.....	10	9	3.50	9	90
Denominational and private residential school.....	13	10	2.30	10	77
Denominational and private day school and class.....	17	14	1.46	15	88
Total.....	233	186	2.20	159	68

In summary, the information in tables I through III suggests that the 127 academic classroom teachers of the deaf graduating in June 1959, will not be sufficient to meet the demand for the 1959-60 academic year. The total number of trained teachers needed is 511. The average annual need per school or class during the past 10 years has been 2.2 teachers. Since 68 percent of the facilities indicated additional needs in the future, it is apparent that means must be developed for the recruiting and training of significantly greater numbers of qualified academic classroom teachers of the deaf.

Until the demand is satisfied, many schools, classes, and clinics are likely to utilize untrained public schoolteachers when it is not possible to procure trained teachers of the deaf. The necessity of inservice training has been a great problem but is now of paramount importance. The staff in schools and classes for the deaf cannot adequately train a number approaching 400 teachers a year while at the same time attempting to educate children in these same schools and classes. The implication, of course, is that the extent and quality of speech and language development and general educational achievement is likely to be less than that desired by those responsible for such training. These factors emphasize the need for trained teachers which, based upon figures in tables I through III, might be as high as 500 per year for the next several years.

Mr. GIAIMO. Are there any questions by the members of the subcommittee.

Thank you very much for your testimony.

Mr. KNITTLE. Thank you.

Mr. GIAIMO. At this time we have about 5 minutes left. I understand that a member of the Connecticut Legislature, Robert T. Cairns, of Madison, is here.

Would you prefer to testify now for 5 or 6 minutes?

It is a pleasure to have you with us today.

STATEMENT OF HON. ROBERT T. CAIRNS, MEMBER, CONNECTICUT STATE LEGISLATURE

Mr. CAIRNS. Mr. Chairman, members of the committee, as a fairly long-time member of the Connecticut Legislature, I thought it might be proper to point out to you that in all of the fields covered by these bills under consideration, Connecticut has been a long-time pioneer and is still giving great thought to it.

In 1861 Dr. Galludet, with Federal and State assistance, started the American School for the Deaf. While it is a private institution we still support it statewide with capital appropriations and tuition grants.

We also have Mystic Oral School, which is completely a State-maintained institution.

Oak Hill along with the Perkins Institute of Boston were pioneers in the education of the blind.

In 1824, Dr. Ely Todd, with State assistance, started the Hartford Retreat, which was the first institution for mental health in the country. That took care of State patients until about 1952 or 1954, when we started our program of mental hospitals.

We now have three of them. All of them are accredited for professional training and I believe are outstanding institutions.

In 1859, Dr. Knight started the first school for mental retardates.

In 1909 we started the Connecticut Colony for Epileptics, and in 1917 these two were merged into the Mansfield Hospital and Training School.

Subsequently we have built the school at Salisbury. These are two of the outstanding schools of the country for mental retardates.

In 1957 we started the Child Study and Treatment Center in Camden, which I believe along with the Menninger Clinic is the first thing of its kind.

In 1955 one of the hospitals in New Haven, Grace Hospital, merged with New Haven and Yale, and the State took that over for purposes very comparable to those contained in H.R. 3465.

We set up a pioneering program in the retraining or rehabilitation of people incapacitated through illness or disease.

Unfortunately, the budget of the last session does not provide for the continuation of that institution and their work is to be split among several others.

However, it was a pioneering effort.

I might also point out that out of a biennial budget of around \$442 million, some \$85 million applies to the subjects of the bills before us: mental retardation, mental health, education of the deaf, the blind, and so on.

Thank you very much.

Mr. GLAIMO. Thank you very much, Mr. Cairns.

Are there any questions by the members of the subcommittee?

Thank you very much for your testimony.

At this time the subcommittee will recess until 1:45 this afternoon.

(Thereupon, at 12:30 p.m., the subcommittee was recessed, to reconvene at 1:45 p.m., same day.)

AFTERNOON SESSION

The subcommittee reconvened at 1:45 p.m., upon the expiration of the recess.

Mr. ELLIOTT. The subcommittee will be in order.

We will proceed now to hear additional witnesses. There are about 17 witnesses for this afternoon. So we must restrict each individual witness somewhat as to time.

Our first witness this afternoon will be Dr. Elias J. Marsh, chief of the Division of Community Services, Connecticut State Department of Mental Health.

Dr. Marsh, will you come around, please sir?

Is Dr. Elias J. Marsh here?

Apparently he is not here.

So next we will hear Miss Virginia Cole, director of the Division of Service for the Blind, State of Vermont.

STATEMENT OF VIRGINIA COLE, DIRECTOR OF THE DIVISION OF SERVICE FOR THE BLIND, STATE OF VERMONT

MISS COLE. Mr. Chairman and members of the committee, as director of the Division of Services for the Blind, in the State of Vermont, I would like to present to this committee some of the unmet needs of the blind people in our State.

I have been a participant in the 2-day workshop held here and endorse the testimony being presented by this group, but I appreciate in addition this privilege of presenting briefly the needs of my State which I feel might be met through Federal Government assistance.

For background information, may I say that Vermont has a population of approximately 265,000 people, about 730 of whom are legally blind.

Probably 430 of these are over 65; 220 are of an employable age, and 80 under 21.

Because these numbers are relatively small this does not lighten the problems which must be faced by each individual blind person. The problems which lack of sight impose upon a person have the greatest variation in relation to the age at which blindness is present. I am therefore presenting these unmet needs on an age-level basis.

I have made a special effort to make this presentation brief.

(1) Preschool blind children: Skilled counseling services to the parents of preschool blind children are a must if normal development is to take place.

In our experience in spite of good counseling, many preschool children show evidence of additional abnormality.

This may be caused by mental retardation, lack of development due to blindness, emotional deviation, emotional disturbance, or brain damage.

At present we have no means of ascertaining the cost of determining such abnormality and no means of treatment. There is abject desperation on the part of the parents of these children due to lack of resources for salvaging the potential of these children.

We, therefore, encourage Federal implementation of provisions for consultation, the training of the professional personnel and technicians and the establishment of diagnostic and treatment facilities on a regional basis which will help bring solution to this serious problem relating to multihandicapped children.

(2) School age children: It has been well proved that a blind child can be educated throughout his minority as adequately as a sighted child, but this is possible only through the provision of extras in all phases of a child's education.

These extras are specialized, technical, and costly, many times over and above many things needed for educating a sighted child.

In our experience in Vermont there is not enough of these extras to go around; we need consultation, technical training, equipment, and supplies over and above what we have funds to supply.

We, therefore, encourage additional Federal aid for the Office of Education, American Printing House for the Blind, the Library of

Congress, and State education departments for additional consultation, training of personnel, and equipment and supplies.

Three, the employable age group: In working under Public Law 565, which provides for vocational rehabilitation we have found that certain restrictions of this law are a deterrent to successful rehabilitation.

These restrictions involve time limits beyond which operating expenses for business enterprises and client maintenance may not be federally reimbursed. Likewise, restrictions in title X of the Social Security Act relating to public assistance acts as a deterrent. These relate to the limited amount of earned income which may be disregarded in determination of economic need for public assistance and the limit in savings or equity which may be built up in a newly established business.

We, therefore, urge that these restrictions be relaxed in such a way that an employable blind person may be enabled to rise above a subsistence level of living in a more realistic and satisfactory manner.

In this age group we find that some persons have disabilities in addition to blindness to such an extent that they cannot expect to attain vocational independence. There is much that can be done, however, to assist them to adjust to restrictions imposed by blindness and to achieve a maximum independence in daily living.

We urge that Congress amend Public Law 565 to enable the States to provide this kind of independent living rehabilitation. We feel strongly that these are services for the blind which should be administered by whatever agencies are already administering vocational rehabilitation for the blind.

Four, the older age group: Whereas upon occasion we provide vocational rehabilitation for a blind person who appears young and vigorous at 75, by and large blind persons over 65 are not seeking employment. The impact of the loss of sight, however, is felt just as keenly and the persons upon whom this calamity has befallen need and can profit by independent living services.

At present we are having to refuse requests for such service for lack of funds.

We urge, therefore, that such independent living services as described for the previous age group not be restricted by any age limit.

In view of the increasing proportion of persons in our population who are over 65 and because blindness is incident with the disease of old age, such as diabetic retinopathy, we strongly urge the support of Congress for any legislation directed toward research in the prevention of such diseases and of other causes of blindness.

Many of the problems related to these four age groups which arise from day to day are of State or local interest and are met adequately or not according to the concern and capacity of the locale.

Constant study is needed on a Federal level for accumulating the best available knowledge toward strengthening and improving services in certain localities so that blind people of all ages in all parts of the country may expect and receive high-quality services directed toward their simulation in and contribution to society.

Thank you, gentlemen.

Mr. ELLIOTT. Thank you very much, Miss Cole.

(The following material was submitted by Virginia Cole:)

[Excerpts from report of the department of social welfare]

SERVICES FOR THE BLIND

There were 135 persons referred to the division during 1956-57 as having become blind, and 154 during 1957-58. As of June 30, 1958, there were 700 names on the register of Vermonters known to be legally blind. This is the largest number in the division's history. The percentage of persons over 65 years shows a continual increase and it is in this age group that the incidence of blindness is on the increase.

Requests for funds for the coming biennium have been limited to the continuance of programs already in existence or started in the past biennium.

Mention should be made of two significant accomplishments in the area of services to Vermont's blind citizens. First, the pilot study on industrial homework which started in 1955 and was completed as of June 30, 1957 was considered successful enough to warrant its continuance under State financing. Its operation is being closely watched not only by the sponsoring agencies, the American Foundation for the Blind, National Industries for the Blind and the Office of Vocational Rehabilitation, but also by other States who are using the Vermont study as a guide to set up similar programs for homebound handicapped persons. Through its appropriation of \$20,000 the State has made it possible for 61 persons to engage in substantial remunerative employment. Thirty-six percent of these persons were blind, the other 64 percent having various cardiac, orthopedic, neurological, and miscellaneous disabilities which precluded their acceptance in the normal labor market. In the 1957-58 fiscal year, a total of \$21,512.46 was earned in wages by these 61 persons. The total cost of operating the program was \$18,990.60. This amounts to a cost of 88 cents per dollar earned. Thirty-nine of these workers gained one or more quarters of social security coverage. The public assistance grants of seven workers were reduced because of these earnings, and it was possible to terminate completely three of the grants. The total reduction of public assistance grants amounts to \$363 per month.

These three factors, significant earnings, social security coverage, and reduced public assistance support would seem to make the industrial homework program a sound investment for Vermont citizens, and it is hoped that in the coming biennium still more persons can be benefited. Acknowledgment should be made to those industrial concerns who have supplied the industrial homework office with subcontract work and have thus cooperated in making this new venture a success.

Secondly, mention should be made of a Federal vocational rehabilitation grant which enabled the division to remodel a building and purchase training and production equipment. Adequate quarters are now available for the industrial homework offices, and for a workshop for the blind, engaged in chair reseatng, machine stitching, and whatever other suitable operations are found to be available. We are now able to expand production operations for Government contracts and the Skilcraft retail sales outlet, thus again increasing the opportunities for earned income for blind Vermonters.

The work in this division has by its very nature a great deal of visible and emotional appeal. It also has a utility aspect in creating areas of usefulness for those who were once almost forced to sit in darkness. Total sales of blind-made articles was \$7,852.30, but it represents much more than dollars and cents. Much emphasis is today placed on rehabilitation. I am sure much interest and pleasure can be derived from a study of the industrial homework project. Vending stand operations earned a gross of \$44,396.52 and a very satisfactory net during the fiscal year. It is hoped to establish two new stands in gainful locations.

Services for the blind, State appropriation No. 16.03

	1956-57	1957-58
Expenditures:		
Salaries and administrative expense	\$29,902.33	\$35,174.95
Supplies and materials	3,288.56	1,622.92
Contractual	7,882.47	9,452.03
Equipment	560.16	909.82
Case service	26,915.39	38,748.26
Total	68,548.91	85,907.98
Receipts:		
Refunds on sale		137.98
Appropriation	38,330.00	48,918.00
Federal funds	30,219.01	34,249.40
Total	68,549.01	83,305.38
Less June 30, 1957, balance	1.10	
		2,602.60
Total	68,548.91	85,907.98

¹ June 30, 1957, overdraft from contingent fund.

[Vermont Department of Social Welfare, Division of Services for the Blind]

Staff: Miss Virginia Cole, director; Mr. D. Kenneth Morrison, supervisor of rehabilitation; Mrs. Margaret C. Lyon, supervisor of special services; Mr. Robert D. Peakes, workshop manager; Mr. Howard Walbridge, rehabilitation counselor; Mrs. Christine Jeffrey, office manager; Mrs. Eloise B. West, account clerk; Mrs. Norma S. Morgan, secretary; Mrs. Alberta Ducharme, clerk.

PROGRAM

Funds are appropriated by the State legislature for the administration and case services of the division. Federal funds are available for the vocational rehabilitation program.

The purposes of services for the blind is to provide opportunities for blind Vermonters to become or continue to be useful, productive members of their homes and communities, and to lead normal and happy lives. An attempt is made by means of the press, radio, and public talks to enlighten the public as to the fact that a person does not lose his ability when he loses his sight, that countless activities can be performed without the use of eyesight, and that blind persons wish to be treated in a direct, normal, everyday manner by their well-meaning, but sometimes overprotective, sighted friends.

The Division of Services for the Blind maintains a register of the blind, furnishes adjustment services, talking-book machines, home industry, medical care, help for parents of blind children, guidance for school-age children, and vocational rehabilitation.

The division has been awarded the Seal of Good Practice by the American Association of Workers for the Blind.

Eligibility for blind services

To be eligible for services from the division, there are the following requirements:

1. *Vision*.—A person must have as little as 20/200 in the better eye with correction, or a limitation in the fields of vision to be at least 20°. This is to be determined by an ophthalmologist.

2. *Age*.—There is no age limit, and clients range in age from infants to those in their nineties.

3. *Residence*.—A person must be residing in the State with the intention to remain.

4. *Economic need*.—Is not determined, except for certain services in the State-Federal vocational rehabilitation program.

Request for service

Requests for service may be made at the State office of the Department of Social Welfare, Montpelier, Vt. The following pages describe these services of the division in some detail.

REGISTER OF BLIND PERSONS

State legislation authorizes the Department of Social Welfare to maintain a register of all known blind persons. This register is maintained on a card file, and contains pertinent information including birthdate, amount of vision, diagnosis, cause and prognosis of eye defect, economic and occupational data, and a summary of services provided.

Such a register is useful for ready reference and for statistical information which might be used in the prevention of blindness.

Confidential information

Any information received in the Division of Services for the Blind, either recorded or unrecorded, is held to be confidential.

MEDICAL CARE FOR THOSE WHO ARE IN NEED

Blind persons do not escape other disease and illness. Doctors, hospitals, and drugs are costly, but are needed by all in order to maintain good health. These services are furnished by the department to the extent that funds are available.

HELP FOR PARENTS OF PRE-SCHOOL BLIND CHILDREN

Advice, encouragement and information are given to parents of preschool blind children, so that they may have a normal, healthy development. Mothers are encouraged to attend Institutes for the Pre-School Blind Child. The department pays the costs of institutes, evaluation, and nursery equipment when parents are unable to do so.

EDUCATION FOR SCHOOL-AGE CHILDREN

The department cooperates with the Division of Special Education in making a sound individual educational plan for each child according to his needs and abilities.

Adjustment services for all

Blindness places upon a person certain restrictions which result in frustration and inactivity. These restrictions include limitation in range and variety of concepts, inability to get about, environmental detachment and arrest of the growth process. To overcome these restrictions and make acceptance of the handicap possible, personal adjustment is provided by whatever means seem most expedient, including any or all of the following:

New tools and gadgets.—These include ordinary household activities such as marked rulers and tape measures, markers for canned goods, clocks, watches and kitchen timers, other kitchen aids, writing boards, braille writers, carpenters' tools, and many other items.

Reading and writing.—Instruction is given in reading and writing braille, use of guideboards for longhand, checkwriting, typewriting, and use of talking-book machines.

Traveling.—Instruction is given in the proper use of the cane, making arrangements for guide dogs, walking with a human guide, importance of listening and muscular memory.

Sense training.—Development of other senses such as hearing, touch, smell, and memory is important.

Hand training.—Hand training is provided for the making of simple useful household articles and repairs.

Recreation.—The newly blinded person is encouraged to continue his recreational activities and add new ones.

Personal care.—Help is given with good grooming, table etiquette, introductions, handling of money, and many other problems of daily living.

Psychological adjustment.—The newly blinded person is helped to face his limitations realistically and to understand the attitudes of sighted persons toward him, so that his frustration will be minimized to the greatest extent possible.

HOME INDUSTRY FOR THOSE WHO ARE HOMEBOUND

Blind persons with manual ability are assisted in designing, producing, and marketing salable products. Supplies are purchased by the department so that quality materials may be had at quantity prices. These materials are sold at cost to the homemaker, and instruction is provided in their fabrication. Finished articles, if salable, are purchased from the client by the department which then becomes responsible for their retail sale. Clients are paid for their labor on a monthly basis. This program provides encouragement and partial financial independence. It may be an end in itself or may be a step in the vocational rehabilitation process.

The department uses a variety of outlets in its sales program. Articles are placed on a consignment basis in many gift shops throughout the State. It seeks cooperation from women's clubs, Granges, PTA's, church groups, and other organizations which sponsor annual sales. Some are sold through regular retail channels. In any case, a 25-percent commission is available for the seller. Blind persons are encouraged to sell their own products, in which case they receive the 25 percent commission.

The department is affiliated with National Industries for the Blind, and Skillcraft, Inc., both of which provide outlets of a wholesale nature through Government orders and a retail sales program with headquarters in Rochester, N.Y.

TALKING-BOOK MACHINES FOR THOSE INTERESTED IN READING

Undoubtedly, the most appreciated single item available for blind people is the talking-book machine. These machines are manufactured by the Federal Government, and distributed to State agencies, who, in turn, lend them to blind persons. The New York State Library in Albany serves the readers of Vermont. The variety and quality of recorded books is extremely good. The records are mailed in a special mailing carton, free of charge. No blind person, who is interested in reading, should be without one of these talking-book machines.

VOCATIONAL REHABILITATION FOR THOSE WHO ARE POTENTIALLY EMPLOYABLE

In this program practically any service is available if it will increase the person's ability to work for pay. These services include:

Vocational counseling.—A thorough evaluation of the person's skills and abilities is made, and guidance provided to determine a suitable vocational goal.

Physical restoration.—Eye, general, and specialty medical examinations are provided; and surgery, medical treatment, hospitalization, and prosthetic appliances may be furnished as found needed. Optical aids are available for persons whose low vision can be improved by some kind of magnification.

Training and equipment.—The department furnishes training, maintenance, transportation, occupational licenses, tools and equipment, job placement, and followup. Training may include institutional, on-the-job, tutorial, correspondence, or personal adjustment. Equipment provided in this manner remains the property of the department, but is designated for the use of the client as long as it is needed by him to gain some financial return.

Supervised business enterprises.—The department develops employment opportunities which are managed by blind persons under supervision. To date these enterprises have been limited to vending stands in public buildings including Federal buildings.

Economic need

For this vocational rehabilitation program, economic need must be established for all services except examinations and counseling.

Source of financing

The Federal Government pays 65 percent of the cost of administration and of the cost of case services for the client with the State paying the balance of such expenses.

Employment opportunities

Employment opportunities include a wide variety of occupations. Blind Vermonters have been engaged in the following as a means of support: Law, ministry, teaching, piano tuning, stenography, insurance, storekeeping, dairy and poultry farming, chair-reseating, telephone operating, taxicab dispatching, housework, electrical repair, janitor service, dishwashing, plumbing, vending

stand operation, lunch-bar operation, many types of industrial work, and many types of home industry.

In spite of this variety, employment opportunities for blind Vermonters are extremely limited. There is great need for more openings.

The general public should know that it is ability, not disability, that counts, and be more willing to accept and have faith in the abilities of blind persons, so that these physically handicapped people will have a chance to show that they, too, have something to give.

The Braille dots on the front cover were transcribed by a blind person, and say: "Obstacles are things to be overcome."

Mr. ELLIOTT. Our next witness here is Mr. Kenneth Shute, director of vocational rehabilitation, New Hampshire Department of Education, Concord, N.H.

STATEMENT OF KENNETH SHUTE, DIRECTOR OF VOCATIONAL REHABILITATION, NEW HAMPSHIRE DEPARTMENT OF EDUCATION, CONCORD, N.H.

Mr. SHUTE. Mr. Chairman and members of the committee, thank you very much for this opportunity to present this statement for our commissioner of education, Charles F. Ritch, Jr.

Mental retardation: New Hampshire has 22 classes at the public school level in 9 of the 48 supervisory unions for the education of the educably retarded child.

A conservative estimate of additional class need in the educable range alone would be 58. There are no classes at the public school level for the education of the trainable child—New Hampshire presently has a permissive law on the statutes in this area.

2. Speech and hearing: New Hampshire State law requires the State department of education to—

prepare, develop, and administer plans to provide educational facilities for the deaf—

including the severely hard of hearing child—above the age of 5 years. Here, again, available funds limit the extent of this program.

3. Neuromuscular and orthopedic: Children who are identified as physically handicapped—by statute—may with the approval of the State board of education, attend public or private school, for the training of such handicapped children, tuition, not to exceed the State average, to be borne by the school district wherein the child resides.

By additional statute a child who is capable of such instruction—in the event that he is not attending such a school as outlined above—shall be instructed in his home for a minimum of 2 hours per week.

The types of children for whom this specialized help is needed includes the epileptic, spastic, and cerebral palsied, among others.

The minimum of 2 hours per week of home instruction in no real sense meets the individual educational needs of such children.

4. Emotionally and mentally ill: New Hampshire has five out-patient clinics, public and private, which work with emotionally handicapped children. One problem in this area concerns the lack of adequately trained personnel, since the range of salaries offered to professional persons is lower than the national minimum for such salaries.

A second major problem is that there are no facilities for in-patient counseling of children within the State, such child patients requiring institutionalization with adults at the State hospital level.

The number of clinics available in the State by no means meets the need for such clinics.

5. Gifted: Although the National Defense Education Act of 1958 provides funds under titles III and V to assist in the education of academically gifted children, many needs are yet to be met at this level which are not being met under existing fund appropriations—with a grant from the fund for the advance of education a program of advanced studies has been operating at a private boys' school for the past 2 years. Experience with this program has indicated the educational depth that can be offered to children at this academically gifted level when funds are available.

Information available, however, would indicate that such a program cannot continue indefinitely without additional funds.

6. Visually impaired: Although the State has within its welfare department a division of blind services, this division works with the legally blind, which may or may not be totally blind.

Another division of that same department works with the visually handicapped, those who are not considered or designated as legally blind.

The State department of education, through Federal subsidization, provides sightsaving materials for educational purposes, but only to the legally blind.

There is need of coordination of blind services, with additional funds to finance these services.

7. Special medical problems: Among the special medical problems are the cardiacs and diabetics who require special help, but who are presently unable to receive the necessary assistance under our present financial structure.

This office is not familiar with the many medical problems which would be apparent under this specialized area, other than to feel that these specialized problems require the same type of financial aid which is evident in the other problem areas listed above.

Specific recommendations: New Hampshire's needs fall into two broad areas:

First, there is a need for additional services for children who have specialized educational needs.

The basic problem here is financial. With additional support, local and regional programs of special education would be possible.

Secondly, there is a need for further leadership at the State level.

Financial support for a director of special education would make it possible to meet that need.

Unmet rehabilitation service needs in New Hampshire:

1. Payment of social security disability insurance has uncovered a large group of people, predominantly in the lower economic group, who present a very difficult vocational rehabilitation problem.

In New Hampshire experience this group presents a need for a great deal of physical restoration and other independent living rehabilitative services of the type represented in H.R. 3465, provision of which would not necessarily lead to a job.

In the absence of a definitive survey, we offer the opinion, based on our experience, that such rehabilitation services for this group outweigh vocational rehabilitation service 4 to 1.

It is recommended that the Congress institute sizable pilot projects to measure more precisely these rehabilitation needs in terms of people and dollars.

It is also recommended that independent living legislation of the type of H.R. 3465 house the activity in the vocational rehabilitation agency, and that this agency be directed to give a high priority to social security disability applicants.

It is further recommended that the Federal laws governing all types of rehabilitation programs be studied with the objective of consolidating as many as possible into one program.

2. The Congress has already recognized the value of comprehensive rehabilitation centers by grant-in-aid funds for their construction.

H.R. 3465 proposes to extend similar support to establishment of sheltered workshops. It is urged that Federal subsidies not exceeding \$10,000 per annum for each sheltered workshop be authorized in order to insure that a given workshop might make a firm demonstration of its worth to its area.

The OVR—office of vocational rehabilitation—publication Workshop for the Disabled, indicates that the sheltered workshop potential is 1 percent of our population. This would indicate a need for workshop facilities in New Hampshire to service 5,600 people. Six sheltered workshops, located in major population centers in New Hampshire, employing 30 disabled workers each, are recommended as a basic minimum for this State.

3. It is an unusual college which has a physical plant so designed as to permit attendance by a severely disabled person.

It is recommended that the Congress take appropriate steps to insure the presence in each region of at least one accredited degree granting institution which would have necessary living and instructional facilities appropriate to a severely disabled student.

Mr. ELLIOTT. Our next witness is Dr. Elias J. Marsh, chief of the division of community services, Connecticut State Department of Mental Health.

Dr. Marsh, it has become necessary that we put a time limitation of 10 minutes. With that understanding, sir, you may proceed.

STATEMENT OF ELIAS J. MARSH, CHIEF, DIVISION OF COMMUNITY SERVICES, CONNECTICUT STATE DEPARTMENT OF MENTAL HEALTH

Mr. MARSH. Thank you very much, Mr. Chairman and other members of the committee. I understand this and I believe I can make my statement quite short.

I am interested in not any specific bill, but in the general problem as you presented it at the opening session this morning, Mr. Chairman.

The great majority of children of school age regardless of whether or not they are enjoying some abstract ideal of perfect health are able to use any school program that provides the range of subject matter and the type of curriculums that progressive educators are now developing.

However, there are many exceptions who for one reason or another cannot adapt to the regular program as offered and for whom special program adjustments must be made or special services provided so

that they may achieve the maximum educational benefits of which they are capable.

These exceptions include some, but by no means all, of the children with orthopedic or neuromuscular speech, mental, visual, intellectual, or emotional defects, defects of such degree of severity as to interfere with their adequate functioning in school.

This is a point particularly to be emphasized since a defect that does not interfere with a child's functioning in school is not a handicap in the present context and hence is not of immediate concern to us.

I believe that unless we are looking forward to a completely paternalistic state it is no real concern of school authorities that a child has cavities in his teeth, enlarged tonsils, or, for example, is a chronic bedwetter.

A start has been made to provide special programs for certain kinds of handicapped children, especially those handicapped by virtue of orthopedic or intellectual difficulties, the classic crippled children's programs and special classes for the mentally retarded.

There is an unfortunate tendency on the part of various groups to seek for more special programs for children with other kind of handicaps. Although these children do require special attention and program adjustments, it is highly dubious that each kind of handicap requires its own special program.

There are variations in adjustments that must be made in details, but these must be provided by the local school authorities in accordance with the requirements of the local situation.

I believe that Federal assistance for special educational programs for handicapped children is indicated; not support, but assistance.

I believe this is an important distinction.

We in Connecticut have been very happy with the stimulating seedling effect that the relatively small Federal grants for community health programs have had. The great beauty of these grants has been the freedom within broad prescriptions left to the States in the specific operation of these programs. They are small, less than \$50,000 a year to Connecticut, but have had tremendous impact.

With these things, for example, we have been able to try out programs of assistance, mental health programs in school systems, aid to psychiatric clinics for children, with a freedom that would not be permitted to us from any other source, which have demonstrated the effectiveness of these programs and in a number of instances we have been able to find other sources of ongoing, continuing support for carrying these on.

This is a pattern of Federal support that I believe is thoroughly justified.

I believe a program of grants-in-aid for the development of special educational services for handicapped children of all kinds could have similar value, but the grants should have a broad base and not be made by specific category of handicap.

I believe that others this afternoon will speak on the special problems of recruitment and training of the specialized personnel in which Federal assistance would be valuable.

We discussed this in the workshops yesterday and the day before and I won't touch on that.

Although I am against special categorical grants, I would like to make a special plea that there be no error in any legislation that is finally made that might exclude special programs or special educational services for the mentally or emotionally disturbed child.

Mr. Irons, of Vermont, made this comment this morning, urging that the word "physically" be deleted from the President's Commission on the Physically Handicapped so that it becomes not the President's Commission on the Physically Handicapped, but the President's Commission on the Handicapped. This is the same sense that I am endorsing right now.

Although I am a child psychiatrist, I do not want to plead for special categorical assistance for the emotionally disturbed child, but I would like to make sure that any assistance that is given for programs not exclude the emotionally disturbed child.

I am aware of the fact that this label is one that has caused a lot of confusion to a great many people, emotionally disturbed child, so I would like to offer a word, not of definition, but of explanation.

Let me make a comparison with a child with rheumatic heart disease for whom special curriculum adjustments must be made. The significant factor for the school authorities is that he must be handled a bit specially. The school authorities accept the medical diagnosis of heart disease and the determination that he needs a special program, but they are not concerned with a definition of rheumatic heart disease; with its etiology, pathology, or the technical details of its diagnosis.

So also with the mental and emotional disorders of children.

Details of etiology and pathology, techniques of diagnoses are the concern of the psychiatrist and his specialized colleagues.

The school authorities come into the picture when the diagnosis and the determination of the handicap have been made.

For a start at a working definition, and I emphasize a start, I would offer the following:

For the purpose of developing special educational programs of services, emotionally or mentally disturbed children are those children who are suffering from an emotional or mental disorder to such an extent as to require a special school program either in their own interest or in the interest of other schoolchildren.

I emphasize particularly that not all emotionally disturbed children require special educational services and for this reason there is no call to try to define in detail what emotional disturbance is, a child whose emotional disturbance is evidenced chiefly by repeated night terrors might require no special program at all.

Likewise a bedwetter. Both of these would probably be considered emotionally disturbed by any authority in the field, but they are not school problems.

On the other hand, a child whose fears make it impossible for him to leave his mother's side so that he can't go to school is a real school problem. It is necessary to have a medical determination that the child's problem is the result of emotional disturbance, but that having been done, details of the diagnosis and so forth are of no concern to the school authorities.

The provision of home instruction on the other hand is. I could give other examples, but I think I have made my point.

A definition of emotional disturbance is no more necessary to our purpose than a definition of rheumatic heart disease, diabetes, or myotrophic lateral sclerosis.

What is important is that once the medical diagnosis and determination of handicap has been made, the handicapped child, whatever the nature of his handicap, mental, emotional, or physical, requires special educational services or programs.

I believe that the Federal Government can appropriately assist the States to develop such special educational programs.

Mr. ELLIOTT. Thank you very much, Doctor.

Are there any questions?

Mr. MARSH. Thank you, Mr. Chairman.

Mr. ELLIOTT. Our next witness is Mrs. Ruth Winer, president of the Massachusetts Association for Occupational Therapy.

Is Mrs. Winer here?

STATEMENT OF RUTH WINER, PRESIDENT, MASSACHUSETTS ASSOCIATION FOR OCCUPATIONAL THERAPY, DIRECTOR OF OCCUPATIONAL THERAPY, BETH ISRAEL HOSPITAL, BOSTON, MASS.

Mrs. WINER. In the State of Massachusetts, overall, in all areas covered by occupational therapists, there is an acute shortage of personnel.

In the department of mental health, alone, of 112 available positions, 75 are vacant or filled by untrained personnel.

The services of the occupational therapist are being expanded, for example, to include training of physically or mentally disabled housewives in homemaking activities by the development of shortcuts in individual housekeeping problems and by the use of splints and gadgets when advisable in order to make the disabled housewife independent.

In working with the mentally retarded, occupational therapists have been found to be the best teachers for these handicapped children, but, out of 30 job openings in Massachusetts, only 1 has been filled.

As job demands increase, the number of students entering training schools continues to fall. As I see it, we are approaching an emergency situation.

People are also leaving the field of occupational therapy. It is not appealing enough to them.

We are dealing with a new field, comparatively, and although the old idea of work versus idleness as a requisite to a satisfactory life is an accepted one, modern concepts of occupational therapy as a scientific approach are not understood by everyone.

A vigorous educational program must be instituted. Rehabilitation procedures should be taught to people in the schools and to the communities.

I don't mean medical people. All of these things that people have talked about here today are not going to really have a good foundation unless basically the public is educated in the technique of rehabilitation.

All these needs that people talk about here today are needs because we are not educated. Even the people here are not educated. Local recruitment endeavors must be financed and initiated. Scholarships and fellowships must be increased.

Finally, the profession of the occupational therapist must be given dignity.

MR. ELLIOTT. You say people are leaving the profession now because of low salaries?

MRS. WINER. Yes, for the very reason we are not considered professionally on a very high side. We are sort of looked down on. We are treated as volunteers in a lot of hospitals.

I am frequently asked if I am a volunteer. The salary is terrible. Training is lax.

All of these fields that people come from here today need occupational therapists.

MR. ELLIOTT. Thank you.

(The formal statement submitted by Mrs. Winer follows:)

STATEMENT BY RUTH WINER, BETH ISRAEL HOSPITAL, BOSTON, MASS.

Within my own experience I am involved in the field of rehabilitation in two capacities:

I. AS DIRECTOR OF THE OCCUPATIONAL THERAPY PROGRAM IN A GENERAL HOSPITAL IN A LARGE CITY

In such a hospital, physical medicine is concerned with two conditions—temporary, with convalescing patients, and long range, with permanently disabled individuals. This requires both an inpatient and outpatient program as well as treatment for patients on home care.

In order to achieve optimum results the combined efforts of all those involved with the patients are necessary. I find treatment most effective when each person has a sound awareness of the function of every other person concerned with the patient's care. Too frequently this is lacking as far as occupational therapy is concerned. It seems to me a more clearly defined concept of the occupational therapist, her procedures, techniques, and goals needs to be developed and education in this area considerably improved as far as anyone having anything to do with rehabilitation is concerned. This should include nurses, social workers, psychologists, doctors, medical students, families, and even occupational therapists, themselves.

For example, a patient with heart disease was admitted to the hospital, having fractured her hip. She was put to bed and informed that it would be several months before she could stand on her leg. A week following admission, she developed a blood clot in the injured leg and became very frightened and depressed. This not only served to aggravate her condition but presented a problem to the doctors and nurses as she became complaining, demanding of their attention, and generally difficult to manage. When occupational therapy was prescribed for this lady, the goal was to relieve her tension through the visits of the therapist and occupation of the patient's time with learning a new craft. She was taught to make a variety of small stuffed toys for her various nieces and nephews. After about 10 days, the change in her disposition was noticeable. As she became more and more absorbed with her work she grew less and less absorbed with herself. As she relaxed she became less agitated. In 2 weeks she improved sufficiently to be discharged to a nursing home.

A hospital stay can be shortened and patients can be helped to become more manageable, but all too frequently there is a failure to recognize this concept.

Outpatients may present different problems. Perhaps the goal is to return a partially paralyzed person to work. Sometimes, an overprotective or unenlightened family neglects to help the patient keep his physical medicine appointments. A social worker may miss the importance of attending immediately to such things as ordering leg braces which will assist the patient in learning to walk when these are prescribed by the doctor. The patient becomes discouraged and fails to make progress in all other areas.

Some patients simply cannot pay the fees required in lengthy treatment or for special equipment such as artificial limbs.

II. AS PRESIDENT OF THE MASSACHUSETTS ASSOCIATION FOR OCCUPATIONAL THERAPY

In the State of Massachusetts, overall, in all areas covered by occupational therapists, there is an acute shortage of personnel.

In the department of mental health, alone, of 112 available positions, 75 are vacant or filled by untrained personnel.

The services of the occupational therapist are being expanded, for example, to include training of physically or mentally disabled housewives in homemaking activities by the development of shortcuts in individual housekeeping problems and by the use of splints and gadgets when advisable in order to make the disabled housewife independent. In working with the mentally retarded, occupational therapists have been found to be the best teachers for these handicapped children; but, out of 30 job openings in Massachusetts, only 1 has been filled.

As job demands increase, the number of students entering training schools continues to fall. As I see it, we are approaching an emergency situation.

We are dealing with a new field, comparatively, and although the old idea of work versus idleness as a requisite to a satisfactory life is an accepted one, modern concepts of occupational therapy as a scientific approach are not understood by everyone.

A vigorous educational program must be instituted to reach anyone having to do with rehabilitation, in the hospitals, in the schools, and in the community. Local recruitment endeavors must be financed and initiated. Scholarships and fellowships must be increased, and finally the profession of the occupational therapist must be given dignity.

We will continue to lose valuable people from a field where they are becoming a necessity unless specific measures are taken to reverse the situation.

Mr. ELLIOTT. Our next witness is Martha Jayne, dean of the College of Nursing, Bridgeport, Conn.

STATEMENT OF MARTHA P. JAYNE, DEAN OF THE COLLEGE OF NURSING, UNIVERSITY OF BRIDGEPORT

Miss JAYNE. Mr. Chairman and members of the committee, I am testifying for our president, James H. Halsey, of the University of Bridgeport.

The University of Bridgeport is a rapidly growing, private, community center, urban university. In the University of Bridgeport are the colleges of education and nursing, whose faculty are aware of the pressing need for more adequate services of special education and rehabilitation.

I have served on the executive committee of the Greater Bridgeport Health Survey. A study, conducted this past year by the American Public Health Association, was made of this community, whose population is over 275,000.

I have also served as the chairman of the study of public health nursing. A three-volume report was published of the health survey. One section in volume 3 was devoted to rehabilitation. However, the need for rehabilitation services and education was evidenced in all three volumes. An active committee of city and university persons are working to formulate a plan to meet these demonstrated needs.

Grants-in-aid and traineeships are needed to provide a coordinated educational and community service program.

Thank you, Mr. Chairman.

Mr. ELLIOTT. Thank you very much for your testimony, which I am sure our full committee and all of us will find to be most helpful.

Miss JAYNE. Thank you.

Mr. ELLIOTT. Our next witnesses are Mr. George Morrison and Mrs. Margaret M. McNally. Mr. George Morrison is president of the Massachusetts Parents Association for Deaf and Hard of Hearing, and Mrs. McNally is corresponding secretary for the Massachusetts Parents Association for Deaf and Hard of Hearing. They will appear together at this time.

You may proceed.

Is Mrs. McNally present?

STATEMENT OF GEORGE MORRISON, PRESIDENT, MASSACHUSETTS ASSOCIATION FOR DEAF AND HARD OF HEARING

Mr. MORRISON. She is present. I will speak for both of us.

Mr. ELLIOTT. You go ahead, Mr. Morrison.

Mr. MORRISON. It struck me as particularly appropriate this morning while listening that this committee was hearing testimony on legislation of this type because it is highly unlikely that any of you would be enjoying your present positions were you not able to hear and communicate freely.

You have heard testimony this morning and this afternoon. You will hear more from expert witnesses who will give you facts and figures. They have titles. I have no title. The one title, though, that I do have which allows me to speak here is the word "daddy."

I am a parent of a deaf child and president of the Massachusetts Parents Association for the Deaf and Hard of Hearing, an organization representing well over 1,000 parents of school-age children in the State of Massachusetts.

We know that given a good education our deaf children can and will be useful, productive citizens who will reflect great credit upon themselves, their communities, and their country.

An enlightened and well-educated citizenry is the bulwark of our defense against alien philosophies and the surest means of assuring to ourselves and our posterity continued economic and social growth in this, our land of freedom.

If more were done for those with hearing losses, their social and economic contributions would add immeasurably to the happiness of all.

The millions whose lives are distorted by the handicap of impaired hearing constitute an enormous potential reservoir of human energy and talent which at present lies dormant and untapped. The horizons are limitless and the search continues for all deaf people to reach their full potential.

In a country such as ours, whose overall educational system guaranteeing an education to all children regardless of race, creed, or color, is the envy of the entire world, it is inconceivable to me that we should keep the door closed to such a large segment of our children by not giving them the education which will enable them to stand shoulder to shoulder with their hearing peers.

What do we, as parents, want? We want more fully trained teachers of the deaf. We want enough teachers of the deaf so that no deaf child need be denied an education. We want our children educated

so that all will be able to work up to their fullest capabilities encompassing all forms of endeavor.

We say give them this good education so that they in turn may go on to honest, gainful employment and higher education and by so doing bear out the wisdom of the Congress of the United States in passing this legislation.

Recently, President Eisenhower, in addressing the Parliament in India, spoke of governments being burdened with "sterile expenditures" for military developments.

Embodied in this bill, under advisement, is the exact antithesis of such barren expenditures. Here is a fertile field, here is an opportunity, rare indeed, for our Government to enact legislation which is ennobling and uplifting.

We feel very strongly that the passage of this bill will help to overcome the critical shortage of properly trained personnel. To the teachers of the deaf, we as parents owe a deep debt of gratitude. Help us to help them train our children.

This is not a inanimate piece of legislation which we are assembled here to plead for. This is a living, vibrant cause to uphold the dignity of man in his everlasting search toward a life free of fear and want, clothed in the mantle of dignified, honest endeavor.

Mr. Chairman, speaking for all parents, everywhere, thank you very much for giving me this opportunity to say what is in the hearts of all of us.

Thank you.

Mr. ELLIOTT. Thank you very much for your testimony this afternoon, Mr. Morrison.

Our next witness is John F. Mungovan, director, Division of the Blind, Department of Education, State of Massachusetts.

Mr. Mungovan.

STATEMENT OF JOHN F. MUNGOVAN, DIRECTOR, DIVISION OF THE BLIND, DEPARTMENT OF EDUCATION, STATE OF MASSACHUSETTS

Mr. MUNGOVAN. The Massachusetts Division of the Blind is a division of the State Department of Education. This division administers comprehensive services to blind and partially sighted persons of the Commonwealth. The services administered by the Massachusetts Division of the Blind are:

1. Aid to the blind. This is a form of financial assistance extended to 2,200 needy blind persons under the provisions of title X of the Social Security Act and pertinent Massachusetts law.

2. Vocational rehabilitation. Services to about 300 blind persons a year.

This program is financed under the provisions of Public Law 565 and State funds. Currently about 70 individuals a year are rehabilitated; that is, retrained and placed into jobs.

This program is still growing in Massachusetts.

3. Home teaching services. This is a State supported program providing instruction to about 600 recently blinded adults each year.

This instruction consists of teaching certain tactile skills such as braille, typing, some handicrafts, and some activities of daily living.

This program frequently provides the newly blinded adult with his first step toward his rehabilitation.

4. Talking book services. This is a reading service provided by the Library of Congress. The division of the blind issues, stores, and repairs the talking-book machines and pays the regional depository of the Library of Congress—Perkins School for the Blind—a fee for handling and storing the records for the 2,000 Massachusetts readers.

5. Sheltered workshops. The division also administers an industrial aid program through the operation of six sheltered workshops employing 110 blind persons.

These are terminal type shops and not rehabilitation centers. They provide work in a protected atmosphere for those who are not able to complete in the world of the sighted.

6. Services to blind and partially seeing children. These services, supported entirely by State funds, include a counseling service to parents of preschool visually handicapped children and social case-work services to school age visually handicapped children and their parents.

Children's workers are active with approximately 200 visually handicapped children of Massachusetts at any one time.

7. Register of the blind. Besides the direct service programs already mentioned, the Massachusetts Division of the Blind maintains a register of all blind persons in the Commonwealth.

About 8,200 blind persons are registered at this time. The registration is accomplished under a law which requires physicians, clinics, and optometrists to report to the division of the blind whenever a patient suffers sufficient loss of vision to render him legally blind.

8. In addition to all these services offered by the division of the blind, the Division of Special Education of the Massachusetts Department of Education provides educational supervision of school age visually handicapped children.

Thus, it can be seen that a complete range of services is made available to blind persons of Massachusetts through the services of this department.

The register of the blind, maintained at this division, is helpful in indicating both current and future demands for services to the blind. There was a total of 8,204 persons on the Massachusetts register on June 30, 1959.

During the 12 months ending June 30, 1959, there were 874 persons added to the register. About half of the persons registered as blind have no sight, and about one-half have partial sight, although listed as blind according to the legal definition of blindness.

Also, about one-half of all the persons registered are over age 65. Children, that is, those persons under age 20, amount to about 11 percent of the registration.

The current trend, and I presume the trend to be expected in the future, is a gradual reduction in the number of children registered because of the control of retrolental fibroplasia and a constant increase in the aged group due to the increasing span of life.

We hope that radiation and its effects does not cause another increase in blindness in children.

Thus, the three major areas of concern in planning programs for the visually handicapped and blind, are these:

1. An increased emphasis on programs to help the aged blind.
2. An increased emphasis on providing educational facilities for blind children during the next 15 years.

Although we can expect a gradual decline in the congenitally blind, the large number of children born blind between the years 1941 and 1956 need to be educated and prepared for a life of independence wherever possible.

3. The middle age group between the ages of 20 and 65 is confronted with the most serious problem of adjustment to blindness, retraining and reentering the labor market in order to seek self-support.

With these broad estimates of the areas of need for the future in mind, I would like to present to your committee, Mr. Chariman, some recommendations as to how these needs might better be met as viewed by the Massachusetts Division of the Blind:

1. Factual background. While a register of the blind is maintained in Massachusetts, I believe much more could be done in measuring the amount of blindness in the United States and in identifying and measuring the needs of blind persons on the one hand, and on identifying and measuring the needs of partially sighted people on the other hand.

Much work needs to be done to define blindness and to provide programs for blind people and it is of equal importance to do the same for persons with poor vision.

The present programs as organized under the commonly accepted definition of blindness fail to make this distinction. This grouping together of blind and partially sighted persons tends, I observe, to work to the disadvantage of the most severely handicapped group; namely, the blind.

I recommend that a careful statistical study be made nationally of the incidence of blindness and the incidence of partial sight and that this study classify blind and partially sighted persons by age, sex, cause of blindness, and vocational potential and the goals of these blind and partially sighted people.

It is not sufficient for program planning purposes to work on an estimate that there are 300,000 blind persons in the United States without describing more accurately who are these blind people.

Data available in Massachusetts could be a stepping stone to such a study, although the Massachusetts Division of the Blind is not staffed in such strength as to assume such a study on its own.

2. Education. Young blind people and partially blind children are now receiving education in residential schools for the blind and in public, private, and parochial schools throughout the State.

Because of the diversity of textbooks used in this variety of schools, a much larger quantity of braille material and other educational aids is needed. Support for an expanded service of individualized books transcribed into braille or on to discs or into large type is needed desperately by school children.

Some provisions for increasing the reader services for high school students is needed despite the wonderful work being done by a very large number of dedicated volunteers now doing this work.

The use of professional readers in educational plans beyond high school is a necessity and is just as much a part of the cost of education as is the cost of tuition, yet the rules of the Office of Vocational Rehabilitation in Washington place reader services as a service to which a means test must be applied but, on the other hand, does not require a means test to determine eligibility for the payment of tuition.

I would urge, therefore, that the office of Vocational Rehabilitation change its regulations so that the means test as an eligibility factor for students engaged in higher education who employ readers, be eliminated.

Considerable scrutiny should be given to the educational service provided by our State schools for the mentally retarded. A substantial number, 27 percent, of blind children are resident in these schools. The provisions for teaching blind children in these State schools could improve considerably with Federal help.

Probably the most important and the most basic skill to be learned by a blind person is the skill of mobility. Mobility training should be an integral part of the education of all blind children.

It is equally necessary to include mobility training in the rehabilitation of newly blinded adults. The skill of teaching mobility is a rare one and few competent teachers are available.

I would recommend, therefore, that the Department of Health, Education, and Welfare establish scholarships and fellowships to stimulate the recruiting of young persons to fill these much-needed positions as mobility teachers for both blind children and newly blinded adults.

3. Vocational rehabilitation. For the middle range age groups, this is the most important service. It helps them get back to work and acquire the independence sought after by most adults.

I have already recommended the removal of the means test as a qualification of a student for professional reader services. From the standpoint of an operating State agency, I would say that the scope of the program and the attitude of the Office of Vocational Rehabilitation are unusually good.

We in the State, however, could be helped considerably in the ultimate job in vocational rehabilitation and that is placement of the blind person into competitive employment. If the staff of the Office of Vocational Rehabilitation were increased to provide experts with special skill in the placement of the blind, these experts could come into a State and work for a period of several weeks at a time.

In these field trips, it would be most helpful if these consultants would actually travel with the State vocational rehabilitation counsellor in job surveys of industrial plants. This service would be a stimulating help to our counsellors who are in the front rank trying to open up employment opportunities for the blind.

4. Aid to the blind. The granting of aid to the blind is frequently a necessary step in relieving the economic stress upon an adult who becomes blind. Through this aid, the blind person is freed of worry over his basic maintenance and can participate freely in planning for his rehabilitation.

The Federal matching formula for aid to the blind should be increased so that the matching per case month is on a base of \$100 instead of the \$65 as it is under the present Social Security Act.

In September 1959, the average grant of assistance in Massachusetts was \$122.86, and the Federal Government matched only \$41.50 of this cost.

It would seem axiomatic that the blinded individual should be provided with the means for a most basic level of maintenance in order to give him the strength and health to participate in a rehabilitation program. The research and training provisions of the Social Security Act should be implemented with appropriations in order to develop the professional skill of aid to the blind staff. For it is with these staff members that the rehabilitation process often begins.

5. Home teaching. This is a very important program within agencies for the blind. Frequently, the home teacher starts the blinded person off toward adjustment to his blindness through teaching some of the elementary skills needed in his functioning as a blind person.

It would help both in the quality and in the quantity of home teaching services if the Department of Health, Education, and Welfare would provide scholarships and fellowships for the training of home teachers and match the salaries of home teachers with Federal funds as is done in the case of vocational rehabilitation counsellors and aid to the blind caseworkers.

I have tried during this brief period to indicate in a terse form some of the ways in which I, as a director of the Massachusetts programs for the blind, see the needs of blind people.

Thank you very much for the opportunity of coming before your committee, Mr. Chairman.

Mr. ELLIOTT. Thank you very much, Mr. Mungovan.

Are there any questions?

Our next witness is Dr. Albert T. Murphy, professor, School of Education, Boston University.

At this time, before you start, Dr. Murphy, the committee will suspend for just a moment while the gentlemen of the press make a few pictures.

(A short recess was taken.)

Mr. ELLIOTT. You may proceed, Dr. Murphy.

STATEMENT OF ALBERT T. MURPHY, PROFESSOR, SCHOOL OF EDUCATION, BOSTON UNIVERSITY

Mr. MURPHY. Mr. Elliott, committee members, my primary affiliation is with the Boston University Speech & Hearing Center. I am speaking also as representative of the Massachusetts Speech & Hearing Association, its president, and also as cochairman of one of the study groups, namely, that on speech, pathology, and audiology.

Dr. Pronovost, who spoke earlier this morning, has mentioned a number of points that I consider particularly salient which I won't repeat, but merely refer to at this point.

The two points that I would like to stress pertain to upgrading present personnel and the necessity for certain kinds of research in the area of speech pathology and audiology.

I think there is no question on the basis of the facts that are being presented to you that there is a great need for a tremendous increase in numbers of workers. We need 5 to 10 times as many trained in

speech pathology and audiology as the New England institutions are producing at the present time.

In addition to the increase in numbers of trained workers necessitated by the increase in incidence, there is a crucial need to upgrade the quality or the competencies of existing personnel.

Many workers in the field of speech and hearing disorders do not have desirable minimal competencies. Many others with basic competencies are in job settings requiring much more advanced training. They have the potential talent. It needs to be nurtured.

New England colleges and universities must develop programs on an advanced graduate level; most of them now are on undergraduate level. They must produce these programs if they are to train the needed workers in speech pathology and audiology.

This will require the addition of high-level courses on the graduate level. These will require additional staff—at least 50-percent increase in the next 4 years, an increase in plant and equipment, if we are to train the numbers of persons that are going to be necessary to handle the increasing incidence that we are here discussing.

Universities must assume responsibility in developing and coordination of workshops and institutes designed to elevate the competencies of present personnel. There must not be merely institutes for speech pathologists and audiologists within their own discipline. There is a crying need for workshops of an interdisciplinary nature, incorporating efforts to educate and to coordinate and to be aided by allied professional areas.

A great variety of causes of speech disorders is a symptom of our relationship to almost all the other areas of speech education and rehabilitation.

Community disorders may be caused by intellectual deviations, emotional or social distress, physical handicaps, all the areas that are being represented at these hearings.

From this and other viewpoints our relationships must be very close with workers who are specialists in the allied areas, the role of medical specialists, nurses, other special educators, guidance workers, regular class teachers, parents, and members of industry in the finding, evaluating, and treating, or educating of persons who are speech defective, hearing disorder, or deaf.

In the area of research, as the final point, the needs are, I think, outstandingly evident. New England desperately needs research in the following areas:

Research in the numbers, the types of disorders, the age distribution of these various kinds of disorders, the geographical location of persons with speech and hearing disorders, especially in relation to the preschool and the aged groups.

We need estimates of the educational and vocational potential of these various persons of various types of handicaps.

We need research involving comparisons of the efficiency of various diagnostic treatment and educational techniques.

We are walking up a blind alley in many of our approaches now. We don't know exactly why we do what we do.

There must be research concerning the desired content, experiences, and duration of training programs to attain stated competency levels.

For example, how much liberal arts training compared to professional training for workers in these fields? What are the possibilities

of completing 4-year programs and 3- and 5-year programs in 4, et cetera?

A person, in order to do full-time work, including summers, often will need assistance in order to get into the working situation more rapidly.

We need research concerning studies of discrepancies between the university product and the school and agency job demands.

For example, analysis of reactions of supervisors in speech, hearing, and other special education and rehabilitation personnel. We need research concerning the evaluation of personnel characteristics of speech pathologists and their eventual job competency to develop prognostic criteria in these respects.

What are the characteristics that we can identify early which will give us an idea as to whether or not this person will be competent, efficient, in this field?

To obtain such basic facts trained workers are necessary. For example, not one audiologist capable of doing such research is being trained in New England at the present time.

We need 20 each year for the next 5 years to begin to meet the need.

Finally, capable research workers usually on the doctorate degree level require grants in aid if they are to be kept from earning their usual salaries by the pursuit of advanced training. At least 40 such grants in aid at the advanced graduate level are needed in the New England area almost immediately.

Thank you.

Mr. ELLIOTT. Thank you very much, Dr. Murphy.

Our next witness is Miss Dorothy Herrman, head school social worker, public schools of Stamford, Conn.

Miss Herrman, I am going to ask the gentleman from Connecticut, Mr. Giaimo, to preside at this point.

STATEMENT OF DOROTHY HERRMAN, HEAD SCHOOL SOCIAL WORKER, PUBLIC SCHOOLS, STAMFORD, CONN.

Miss HERRMAN. I appreciate very much the opportunity to be here today, although I am not going to be speaking on any of the particular bills which are before this committee, the House of Representatives bill No. 3465 does indicate this committee's interest in the matter of rehabilitation services for the mentally ill who are able to live in their own home.

I would like to speak today about the need for Federal support for preventive services for schoolchildren in order that the child may not develop into an adult with such severe problems that hospitalization is necessary.

Before discussing the areas in which the Federal Government can be of help in the field of special education, I would like to comment on the philosophy behind, and rationale for, public schools spending money to provide these services such as classes for children with special educational needs from the gifted to the retarded, or offering services such as speech therapy or casework services.

Since the public school of today must educate all children—not just the physically and emotionally well child with average intelligence—

the school has of necessity had to offer services for those children who are unable to utilize the regular school program.

In addition, special services, particularly psychological and school social work services, are important because of their preventative aspects.

Mental illness is our No. 1 public health problem, since 1 person out of 10 will sometimes need hospitalization for such difficulties.

Obviously, the cost of this problem cannot be met purely by individuals, municipalities, or the State.

I might just divert from what I have written here to say that certainly the comments that Dr. Murphy was making about the need for funds in research apply—I cannot quote statistics and figures—but the need for research around the causes of mental illness is a whole area that needs to be given a great deal of consideration.

Federal assistance to States, I feel, is needed in three areas in the field of special education:

(1) Recruitment and training of the various specialists needed to provide services, because of the serious lack of enough trained people in all these fields;

(2) In the development of research projects, the cost of which cannot be met by local communities; and

(3) In the establishment of direct services; again an area often affected by lack of funds.

In order to illustrate the effectiveness of one type of special service, I would like to tell you something about school social work service in Stamford, Conn., a community of approximately 90,000 with 14,000 public-school children. This is a community representing a cross-section of people from varied economic, racial, and religious backgrounds.

Last year, 1958-59, school social workers provided direct casework service to 6.7 percent of the elementary children and their families in schools with this service. These are children whose emotional problems or poor social relationships made for such difficulties that they could not adequately utilize their educational experiences.

These are children many of whom have average or above intelligence, but are achieving far below their capacity.

These are children who without casework service when they are small, may develop more serious problems later.

These are children who are concerned about their problems and want help to overcome them.

Of this 6.7 percent given casework service in school, 6 percent needed and were referred to psychiatric treatment.

If we apply Stamford's figures regarding children needing one of the special educational services—school social work—to the country as a whole, the size of the problem is almost staggering. But, also, the potential for preventative mental health services is most apparent.

I hope that this committee can develop ways of assisting our communities and States to more adequately meet the needs of children.

Mr. GIAIMO. Thank you.

The next witness that the subcommittee will hear will be Edmund B. Boatner, superintendent, American School for Deaf, West Hartford, Conn.

You may proceed, Mr. Boatner.

STATEMENT OF EDMUND B. BOATNER, SUPERINTENDENT, AMERICAN SCHOOL FOR DEAF, WEST HARTFORD, CONN.

Mr. BOATNER. Mr. Chairman, gentlemen of the committee, I am glad to have the opportunity to speak before you today.

I am particularly interested in House Joint Resolution 494, title I, particularly, which I feel more qualified to speak on since I have been in this field for 27 years.

I am in very hearty accord with the provisions of this resolution. You are familiar with the facts as outlined in the resolution which says that 150 teachers are being trained each year, approximately, in recent years, where some 500 are needed.

Actually, the facts are more unfavorable than that.

There were 130 teachers last year trained in all the training centers and there are always a number from foreign countries. Also, some go into other work; that is, not directly into teaching.

So we had considerably less than 130 and less than one-fourth of the number of teachers needed to replace just the ordinary retirement and other factors that lead teachers to drop out of the active field.

The greatest single factor is undoubtedly financial because it means that a teacher who trains has to give up a year's earning power and in many cases they have to pay for the training. This is quite a big problem to most individuals. No doubt this is the reason why six of the training centers had no enrollees at all during the past year.

There is a further limitation on the training of teachers of the deaf. That is imposed by the requirement for extensive practice teaching, which means that a single training center which uses a school for the deaf can usually handle not more than 12 students in any one year because more would be disruptive of the regular school-work.

Therefore, it is obvious that other training centers are needed, and, if this financial support is available to help these centers be established, I believe they will be, and will be a source of additional trained teachers.

At the present time there is only one training center in New England. It is a very fine center. They have 12 students this year. I am sure there are some foreign students there as there usually are.

At the American School for the Deaf we have had a desire for many years to establish a training center but the financial problems and other factors have prevented us from doing so. We hope to establish such a center in connection with some college in the Hartford area.

This bill would probably aid greatly toward this end.

Now, you probably wonder how our schools are getting on when these teacher shortages are so acute. Most schools have to resort to inservice training and sometimes to superannuated teachers. This presents a most undesirable situation. While we in most schools have to do it to some extent, in some areas, such as in the South, I am sure they have to resort to it to a great extent.

It is extremely difficult to impart to inservice trainees the background, techniques, and highly specialized skills of a successful teacher of the deaf.

I don't say it cannot be done: I just say it is extremely difficult and in many cases I know it may never be accomplished.

In this regard I am sure it is difficult for a layman or even an experienced teacher to understand all the problems incident to imparting language, reading skills, lip reading, speech—all of those skills and subjects that are needed to train a deaf child.

In fact, this makes this the most complex of all fields, with the exception of the deaf-blind, of which there are less than a hundred.

I think 78 were listed in the last census. The teaching skills necessary to approach this problem cannot be picked up readily in a few weeks. They require intensive training, extensive practice teaching, and then they have to have years of experience to make a really able teacher.

For example, a child of 6 years without preschool training who is deaf may have equal intellectual ability with one who has good hearing, may enter a school for the deaf at the age of 6, who without preschool training, would have no concept of words as compared to this more fortunate child who has all of his hearing, who would have all the spoken language he would need to get along in his everyday needs.

There are many other illustrations, but I cite these to show the complexity of this field and why the need for training is so imperative.

But I would like to say something about the deaf, themselves, which I believe you might be interested in.

Our school was the first one to be established in the United States in 1870. Since that time the deaf of this country through education acquired in this and now in many other schools have coped with the problems of life successfully as good citizens. They are a group of people who have never received a great deal of philanthropy, and all too little sympathy because they are handicapped. Their handicap is a lifelong handicap.

Think, for a moment, what it excludes them from, the usual give and take of conversation, the use of the telephone, the joys of music, many occupational pursuits.

These are only some of the deprivations which deafness brings.

Through all of this the deaf have never asked for anything, but an education. They have gone out and made their own way with a fierce independence.

I bring to your attention this one instance which in my estimation deserves a memorial of some sort in the lobby of the National Capitol.

A bill was introduced in Congress some years ago by Senator Langer of North Dakota, the aim of which was to give an additional \$600 tax exemption to deaf persons. This was officially opposed by the National Association for the Deaf. It pointed out that while all of them needed the money the deaf felt they should not be excused from any of the obligations of citizenship.

Where can you find a better example of citizenship.

So it seems to me that we owe to deaf people the proper opportunities for satisfactory education which is all they ask, but which under the present circumstances they cannot get.

So far as I know the Federal Government has done nothing to help the education of deaf children of the elementary and secondary level.

since in 1819 they granted some 23,000 acres of land to help establish the school in Hartford.

I hope in this emergency we have come to the time when once again the Federal Government will extend aid to education of deaf children at that age which will insure them at least well trained teachers.

Thank you.

Mr. GLAIMO. Thank you very much, Mr. Boatner.

Are there any questions of Mr. Boatner by members of the subcommittee.

At this time we will hear the next witness, Adam J. Sortini, director, Hearing and Speech Clinic, Children's Medical Center, Boston, Mass.

You may proceed.

STATEMENT OF ADAM J. SORTINI, DIRECTOR, HEARING AND SPEECH CLINIC, CHILDREN'S MEDICAL CENTER, BOSTON, MASS.

Mr. SORTINI. If I may be permitted, I prefer to stand.

I also would like to suggest that my manuscript here be submitted, since I will not read it as written, but refer to it occasionally.

Mr. GLAIMO. Then you want to present that as a formal statement to be incorporated in the record?

Mr. SORTINI. Yes, please.

Mr. GLAIMO. Without objection, that will be done.

(The formal statement submitted by Mr. Sortini follows:)

FINAL REPORT OF THE MASSACHUSETTS COMMITTEE TO MIDCENTURY WHITE HOUSE CONFERENCE ON CHILDREN AND YOUTH

Beyond the provision for education of the school age child, however, there are further inadequacies in the Massachusetts program for the preschool handicapped child with sensory defects. There is, for example, no statewide program to prepare the child who is severely handicapped to participate successfully in formal education. A speech clinic for preschool children has just been established at the Children's Medical Center.

The parents of deaf and blind children are currently groping for help with their problems. Parents need advice about their own attitudes, feelings, and responsibilities for the child and his handicap, as well as with the specific training difficulties presented by the child. Little has been offered even under private auspices, either by a group or an individual approach, to aid parents in this respect.

Emotional problems may be present in children who are blind or deaf as well as in children who are not handicapped. Very little recognition, however, has been given to the needs of these children in the psychiatric field. This service is badly needed to prevent children who may be emotionally disturbed, rather than intellectually retarded from being considered feeble-minded and institutionalized. While Massachusetts has a few day classes for deaf children, there has been no similar development for blind children. With the current emphasis on nonsegregation of the handicapped child and the value of the child remaining with his own family group, this lack in our community program deserves consideration.

None of these children with sensory handicaps receive help under the crippled children's program in Massachusetts, yet many of them are severely disabled and need every medical facility available for all possible correction for their disabilities if they are to have a minimum of personality damage from their handicaps. No provision is now made except under private auspices for the correction or alleviation of any of these conditions in the preschool child. The Massachusetts Eye and Ear Infirmary has done extremely valuable pioneering with the problem of deafness under the auspices of the Winthrop Foundation and Clinic, both in service to this younger group and in important research into causes and

treatment. Valuable assistance is given to the preschool blind child, which includes service to the parents of these children. Governor Dever has recently proposed that a special hospital school be established for blind, mentally retarded babies.

REPORT OF THE SPECIAL COMMISSION TO STUDY AND INVESTIGATE CERTAIN PUBLIC HEALTH MATTERS UNDER CHAPTER 78 OF THE RESOLVES OF 1948, DECEMBER 1, 1948 (THE COMMONWEALTH OF MASSACHUSETTS)

CHILDREN WITH IMPAIRED HEARING

Massachusetts is one of the leading States in the detection of hearing impairment. Recently developed has been the Massachusetts hearing tests, which is described as being the first practical method of screening masses of children by way of group pure-tone method. The State department of health undertakes the service in smaller communities by means of State-owned apparatus. It is our opinion that Massachusetts is rapidly developing a satisfactory system which will operate from the rural level to the large city level with equal success. The problem, however, is that of arranging proper therapy if the impairment in hearing is detected. Furthermore, in the preschool age group, if our information is correct, no State program exists for the detection, treatment, or early education of the deaf child. It would seem desirable to have a plan on a State level which would provide consultative and diagnostic aid, and which would provide for the treatment that is indicated for the medically indigent. It would seem proper to provide hearing aids for such patients when necessary and to provide through a home study plan for the education of the parent of preschool deaf children.

Lipreading is an extremely important element in dealing with children whose speech is impaired or whose hearing for speech will in all likelihood be impaired. It is our impression that there is a tremendous variation in the quantity and quality of instruction of lipreading from town to town, but that reading instruction does not give rise to the same difficulties as the sightsaving classes, since lipreading is commonly administered as a supplement to the child's regular educational program, and the children are not uprooted from their normal classroom environment.

In connection with the comment under lipreading, it should be considered that the same teacher who develops competence in speech training might, likewise, be the one who develops the techniques of teaching lipreading.

Specific recommendations for the hard of hearing

1. Regional hearing conservation clinics, similar in distribution to the orthopedic clinics of the Services for Crippled Children, should be planned to give diagnostic aid, advice, and treatment for children with impaired hearing. These clinics should be under the Services for Crippled Children. Children patients should ordinarily be referred by way of the family physician; but in the instance of the known medically indigent, reference might be made directly from the school to the clinic. Children of preschool age as well as schoolchildren should be admitted to such a clinic. It is suggested that this program be developed in one area in an exploratory manner. The program should then be expanded as indicated.

2. Hospitalization should be provided for the medically indigent as necessary. This should be provided in existing teaching units, and funds should be made available to support the cost of hospitalization.

3. Where necessary, as determined by financial incapacity of the patient, the Commonwealth should provide for the purchase in part or in full for the hearing aid for that child.

4. The Commonwealth should provide, through the department of education, a home study course which would enable the parents to begin the education of the deaf child at an early age. (Example: The home study course of the John Tracy Clinic at Los Angeles, Calif.)

5. See lipreading above.

SPEECH DEFECTS

The services for crippled children in the Commonwealth have had only one speech therapist to cover the whole State. It has been one of her duties, among others, to attend the crippled children's clinic, giving instructions at that time. At present, this position is unfilled and there is no speech therapist participating

in the program. The committee has not had time to investigate the speech training in our schools; the impression is obtained that it is not covered adequately.

Recommendations

1. The amount of speech training and its efficiency in our schools should be investigated.

2. Additional speech therapists should be added to the crippled children's services.

3. Speech therapy should be added to our public school programs as far as possible.

It is suggested that a teacher in each of our public schools should have a certain competence in speech instruction so that pupils with speech defects may have corrective exercises.

4. The department of education should develop and support the necessary facilities for the instruction of teachers in speech therapy. The possibility for summer courses for this instruction should be considered.

5. The speech therapists at the State level, under the crippled children's service, should be available for consultation with the teachers regarding the individual children who have such defects. It is suggested that it is ideal that a therapist of these services should see each child and make specific recommendations to the speech instructor in the school. This would mean that individuals of lesser competence could carry on the school program.

6. A committee should be appointed to study this whole problem in detail and make more detailed and specific recommendations.

STUDY OF FACILITIES FOR THE HEARING HANDICAPPED, METROPOLITAN BOSTON, 1956-57

(Rehabilitation Council, Health, Hospitals, and Medical Care Division, United Community Services of Metropolitan Boston)

Dr. Janet Hardy, director of the Division of Maternal and Child Health, Baltimore City Health Department and a member of the staff of the Johns Hopkins Medical School and School of Hygiene, was engaged to get as complete a picture as possible, in a limited time, of—

1. Services and facilities, medical, social, and educational, including rehabilitation for the deaf and hard of hearing in Metropolitan Boston.

2. Any overlapping or reduplication of services.

3. Unmet needs in the areas mentioned above.

Dr. Hardy interviewed personnel in agencies and groups interested in or responsible for providing services to meet the needs of the hearing handicapped. These interviews were essentially unstructured but were designed to elicit information as to the types, quantity, and quality of services given, unmet needs, and how services of one agency fitted in with those offered by others.

The emphasis of this survey has been placed intentionally on services for children, although the problem of the adult hearing handicapped is also covered. Case finding, diagnosis, treatment, and education of the child constitute the best preventive to adult problems.

The Sarah Fuller Foundation for Little Deaf Children has given service in Metropolitan Boston since 1888. In recent years this service has been restricted to home teaching of the very young deaf child. On September 1, 1957, the resources of the foundation were transferred to the Speech and Hearing Clinic of the Children's Medical Center. The foundation will continue to offer home teaching under the auspices of the Children's Medical Center, and will also see patients there.

The number of nursery school sessions that a hearing handicapped child attends per week depends on the needs of the child, the time that the parent can give to transport the child to the school, and the availability of trained teacher.

The shortage of trained teachers and transportation problems probably have more influence on the amount of teaching a child gets than do the child's needs.

The mentally retarded deaf child does present a problem of placement. The Horace Mann School for the Deaf has a class for the mentally retarded deaf child. However, this class is not adequate for the number of children who have both handicaps. There is a difference of opinion among experts regarding the proper type of placement for a child with both handicaps. The choice lies between a school for the deaf or for the mentally retarded, since no combination school is available. There are practically no scientific data on which to base the decision, as to which school a child should attend.

The superintendents of each of the four State schools for the mentally retarded in Massachusetts have expressed interest in creating a special unit for the mentally retarded who also have a serious hearing handicap. There are only four such programs in the country: Sonoma State Hospital, California; Faribault State School and Hospital, Faribault, Minn.; Wheat Ridge State Home and Training School, Colorado; and the Pacific State Hospital, California.

"The need for trained teachers of the deaf is probably the most critical problem * * * in the field of services for the deaf * * * throughout the world today."

The lack of teachers in Massachusetts is due partly to a salary differential in favor of adjacent States and partly to the fact that too few teachers are entering this field.

Dr. Hardy felt that certification of teachers of the deaf in Massachusetts and a salary differential between teachers of the deaf and teachers of normal children would contribute to attracting more to the field.

An aggressive recruitment program, scholarships for the Clarke School program, and/or a training facility in an urban area should attract more teachers to this profession.

Although this study is specifically concerned with the hearing handicapped, it is our opinion that schools, colleges, and medical centers in the area should give thought to developing more training programs for teachers of children with all types of handicaps. With relation to our specific interest, recruitment and an urban training facility seem to be the answer.

Therefore, it is recommended that:

III. Interested citizens, schools for the deaf, and voluntary and official agencies concerned with the problems of the hearing handicapped promote an educational program to interest students and teachers in the profession of teaching the deaf. This program should be concentrated, at least in the beginning, on the audience that is calculated to have the highest potential for this profession; namely, teachers who have had successful experience in teaching normal children.

IV. Recognized educational institutions, medical centers, and schools for the deaf in Metropolitan Boston be made cognizant of the need for a local facility for training teachers of the deaf and steps be taken to interest them in developing a facility that meets the standards for accreditation of training centers for the deaf of the Conference of Executives of the American Schools for the Deaf.

A short course, offered by a school or schools for the deaf, for workers in community agencies on the special aspects of the deaf would be helpful. This would naturally cost money.

Therefore, we recommend that:

V. The State department of education, the schools for the deaf, the Boston Guild for the Hard of Hearing, and the Massachusetts Parents' Association confer to find ways and means to sponsor and organize a training program for workers in community agencies on the special needs of the deaf. This program should be repeated as often as necessary.

VI. The appropriate agency—possibly the Massachusetts Department of Public Health or the Massachusetts Department of Education or both cooperatively—setup a research project which will provide basic, descriptive, meaningful data on the character of hearing impairments and their prognosis as a basis for (1) community planning, (2) developing standards for recommending specialized services for the hearing handicapped, and (3) training the various professions working with the hearing handicapped.

Therefore, it is our feeling that in a metropolitan area all these services should be under one roof, and that should be the roof of a medical center or centers; even though many of the services involved in this process are not medical, they are educational. Only a medical center can offer the basic highly specialized medical services. However, educational services in a medical setting should be supervised by an educator. The audiologic services should be handled by an audiologist and the otologic services by an otologist. In short, each specialist should be responsible for the technical operation and content of his own program.

The functions of such a hearing center have been delineated by the bureau of handicapped children in the New York City Department of Health:

(1) It should provide complete services for the diagnosis, treatment, and rehabilitation of children and adults who have or are suspected of having a hearing impairment.

(2) It should care for not only patients usually known to the hospital but also patients referred to it by practicing physicians, community agencies, school health services, and industry.

(3) It should provide interpretation and guidance to the patient and his family and should assist them in making the necessary plans for the patient's total maximum rehabilitation.

(4) It should be a training center for professional personnel of all types, both at the undergraduate and postgraduate levels.

(5) It should perform research.

RECOMMENDATIONS

I. The rehabilitation council of united community services appoint a standing committee representing all of the specialties giving service to the hearing handicapped and those who receive these services (1) to organize periodic institutes or workshops, which will bring together all workers in the field of service to the hearing handicapped, to get acquainted, to exchange ideas, to work on common problems, to learn about new programs, discuss current thinking in the field, etc.; (2) to develop a master plan of services for the hearing handicapped in Metropolitan Boston and to use as a basis for this plan this report and the thinking of all who are working with the hearing handicapped as expressed at the first institute or workshop.

II. United community services through the health division give staff assistance to this standing committee to help it get started, and maintain contact with it until the coordinated approach of the various specialties serving the hearing handicapped has matured sufficiently so that the "hearing profession" can assume total responsibility for its own program.

III. Interested citizens, schools for the deaf, and voluntary and official agencies concerned with the problems of the hearing handicapped promote an educational program to interest students and teachers in the profession of teaching the deaf. This program should be concentrated, at least in the beginning, on the audience that is calculated to have the highest potential for this profession; namely, teachers who have had successful experience in teaching normal children.

IV. Recognized educational institutions (for example, Harvard University, Simmons College, Boston University, Emerson College, and Boston College), medical centers, and schools for the deaf in Metropolitan Boston be made cognizant of the need for a local facility for training teachers of the deaf and steps be taken to interest them in developing a facility that meets the standards for accreditation of training centers for the deaf of the conference of executives of the American Schools for the Deaf (American Annals of the Deaf, vol. 101, January 1956, Gallaudet College, Washington, D.C.).

V. The State department of education, the schools for the deaf, the Boston Guild for the Hard of Hearing, and the Massachusetts Parents' Association confer to find ways and means to sponsor and organize a training program for workers in community agencies on the special needs of the deaf. This program should be repeated as often as necessary.

VI. The appropriate agency—possibly the Massachusetts Department of Public Health or the Massachusetts Department of Education or both cooperatively—set up a research project which will provide basic, descriptive, meaningful data on the character of hearing impairments and their prognosis as a basis for (1) community planning, (2) developing standards for recommending specialized services for the hearing handicapped, and (3) training the various professions working with the hearing handicapped.

VII. An objective group of trained, competent specialists review the 1947 Harvard research, determine whether other research has been done in this area, and review the experiences of agencies in Boston and other communities in the use of hearing aid evaluation in an attempt to resolve the question of the value of this service to the hearing handicapped.

VIII. The Boston Guild for the Hard of Hearing not increase its present capacity for hearing aid evaluation, and commence negotiations with one of the Boston medical centers concerned with the hearing handicapped to arrange either to transfer this activity to that center, or to develop a cooperative arrangement that will insure adequate supervision and followup.

IX. The Boston University Speech and Hearing Center negotiate with one of the Boston medical centers concerned with the hearing handicapped either

to transfer this activity to the center or to develop a cooperative arrangement that will insure adequate supervision and followup.

X. Private agencies that have been using their resources to purchase hearing aids for children consider diverting these funds for other purposes.

XI. The medical centers in metropolitan Boston interested in the problems of the deaf and hard of hearing confer with the educators, the audiologists, and all other people involved, to discuss the idea of a hearing center and work out a plan that will give the Boston area this resource.

XII. Representatives from the State departments of education and public health, a medical center (interested in housing a hearing center), the Boston Guild for the Hard of Hearing, the Massachusetts Parents' Association for the Deaf and Hard of Hearing, and other interested organizations work out a plan for the regionalization of therapeutic services for the hearing handicapped.

XIII. A committee of competent persons in the field of service to the deaf and in the recreation field, including representatives from the Boston Children's Service Association, the Boston Guild for the Hard of Hearing, the Massachusetts Parents' Association, the schools for the deaf, and the recreation, informal education, and group work division of united community services work together to develop a facility that will offer comprehensive recreational and social activities for persons with a hearing disability who has not developed normal speech.

XIV. The availability of hearing screening tests to the parochial school population and the importance of this service to the child be brought to the attention of the proper authorities in the parochial schools in the archdiocese of Boston.

A SURVEY OF THE FACILITIES AND NEEDS FOR THE DEAF AND HARD OF HEARING IN THE GREATER BOSTON AREA

This project was undertaken upon the request of the United Community Services of Greater Boston. Miss Helen Cleary, staff member of the United Community Services was of inestimable help in organizing the survey and without her help it would not have been possible.

This project was undertaken by me upon the recommendation of Dr. William Hardy, director of the Johns Hopkins Hearing and Speech Center. Dr. Hardy has been most helpful in being available to me for discussion and consultation with reference to the project.

This project would not have been possible without the interest and cooperation of all the various agencies and groups contacted in the course of the survey. This was forthcoming in great measure.

Janet B. Hardy, M.D., director, Section of Preventive Medicine, Baltimore City Health Department; assistant professor of pediatrics, Johns Hopkins University; lecturer, public health administration, Johns Hopkins School of Hygiene and Public Health.

The following information contains, in essence, the findings and recommendations of Dr. Hardy concerning the hearing clinic at the Children's Medical Center.

"Facilities here are very limited from the point of space and from the point of proper soundproofing. However, they are treated to produce sound deadening and all the essential equipment seems to be there, including provision for psychogalvanic methods of testing."

"The volume of work going through the hearing clinic would appear to necessitate additional staff and additional space.

"As the medically oriented diagnostic facilities for children in this area are limited and as the importance of this type of work receives increasing recognition the already increasing patient load will grow further. It would seem that long-range plans should be made for developing a really first-rate speech and hearing center at the Boston Children's with close liaison with the educational group for preschool children.

"This center should be planned with a view to:

"(a) Providing patient service.

"(b) As a research center.

"(c) For training personnel.

"With respect to the latter point there is a great need for medically oriented audiologists in this country, perhaps some liaison could be worked out with one of the graduate schools in the Boston area.

"(d) For house staff and medical student observation and teaching."

NOVEMBER 30, 1959.

DR. WILLIAM SCHMIDT,
Harvard School of Public Health,
Boston, Mass.

DEAR BILL: Further to our recent conversation with George Starbuck, I am forwarding to you copies of my reports as chairman of the Committee on Accident Prevention of the Massachusetts Chapter of the American Academy of Pediatrics. This may not represent entirely a complete picture of what is going on in the State, but probably Miss DiCicco of the State department of health can fill things in.

I should also like to urge that your committee consider seriously making some strong recommendations regarding the present shortcomings of Massachusetts with respect to maintaining a system which is adequate for producing teachers qualified to manage the problems of the handicapped. My understanding is that our teachers' colleges provide little or no opportunities for training of this sort. This has been a longstanding deficiency of the department of education. In addition, I know of no extra inducements, salarywise, for teachers to enter this field. I would not expect the number of such teachers ever to be very great in view of the special interests and aptitudes involved, but they are sorely needed at the present time, and we must have more of them if our efforts to train and educate young folk with special problems are to be effective. My budget committee in UCS which has to deal with rehabilitation facilities has been encouraging the Boston Guild for the hard of hearing to develop community interests in meeting the problems of the deaf and hard of hearing. However, any local interest generated will wither when there are demonstrably few or no teachers to be found. This longstanding problem was mentioned in my 1930 White House conference report and in the reports of the last two State health commissions.

Yours,

LONDON SNEDEKER, M.D., *Assistant Director.*

MR. SORTINI. I think you gentlemen have been listening to facts and figures. As I have been sitting here over the past half hour I have been watching Mr. Daniels. For example, I don't know whether or not he can speak because I have not heard him speak.

This gentleman here has been doing some stenotyping.

As I speak, I am communicating in one way through his using that machine and as Mr. Daniels looks at me he can communicate with me by saying something to me.

The point I am trying to make is that I think perhaps the most intimate form of communication in our society is being able to speak. If we cannot speak, if you gentlemen were not able to speak, you would not be where you are.

If I were not able to speak perhaps I would not be here.

So with all the handicaps, although we must admit and we well realize in the field of speech and hearing that some handicaps are equally as important as the others.

At least from my way of thinking I think perhaps the most crippling type of handicap is an inability to express one's ideas. If we have a form of handicap where we are unable to express our ideas, then we are not living—we are existing.

Now, there have been any number of research studies of a general nature. For example, the Commonwealth of Massachusetts report of the special commission to study and investigate certain public health matters on December 1948 at that time suggested that regional hearing conservation clinics should be planned to give diagnostic aid, advice and treatment to children with impaired hearing.

It suggested the children with speech defects in the whole State of Massachusetts were being serviced at the State level by one person through crippled children's services and it suggested further research.

In 1951, in the mid-century White House Conference on Children and Youth, it stated that there were inadequacies in the Massachusetts program for the preschool handicapped child with sensory defects.

It mentioned that parents of these children were groping for help with their problems, parents needed advice about their own attitudes, feelings, and responsibilities.

Very little recognition has been given to the needs of these children in the psychiatric field.

The Massachusetts Eye and Ear Infirmary, it was mentioned at that time, has done extremely valuable pioneering work with the problem of deafness and it was mentioned that in 1951 a hearing clinic had been established at the Children's Medical Center in Boston.

I started with the Children's Medical Center as director of the hearing clinic on July 1, 1951. I typed my own letters for 6 months.

Eight years later I have a staff of 14 people. If we were able to find the people, if we were able to provide some training grants, if we had funds, we could add seven more people immediately to my staff—immediately.

I have submitted as part of my testimony a picture of my testing area. This testing area includes an operator's room which is 7 by 7 feet, for 49 square feet and a testing room of 7 by 13 feet, which is 91, or a total of 140 square feet.

In this total work area of 140 square feet I see 2,000 children a year. My staff of 12 professional people and 2 secretaries last year, in 1958, saw 7,500 children with speech and hearing problems.

Speech and hearing problems are here to stay. As further testimony, in 1956 Dr. Janet Hardy from Baltimore was asked to come to Boston to make a survey of the facilities and needs for the deaf and hard of hearing in Greater Boston. The following information is from Dr. Hardy's recommendations concerning the hearing clinic at the Children's Medical Center:

Facilities here are very limited from the point of space and from the point of proper soundproofing. The volume of work going through the hearing clinic would appear to necessitate additional staff and additional space.

It would seem that long-range plans should be made for developing a really first-rate speech and hearing center at the Boston Children's Hospital with a view toward providing patient services, as a research center, and as a center for training personnel.

Our hospital—and speaking for our hospital alone—has two major functions. We are a diagnostic center; we are a training center.

In 1956 to 1957 the United Community Services presented a report and several major recommendations were made, again pointing out the fact that there was great need for educational institutions among these Boston University, Emerson College, Harvard University, Simmons College, to set up training programs.

The final piece of testimony is dated November 30, 1959. You see, gentlemen, we have gone from 1948 through 1959. We have been talking and talking. Now we must do something.

This is dated November 30, 1959. It is a statement by Dr. London Snedeker, assistant administrator, Children's Crippled Center, to Dr. Schmidt of the Harvard School of Public Health. This is in part a report of the Massachusetts chapter of the American Academy of Pediatrics:

I should like to urge that your committee consider seriously making strong recommendations regarding the present shortcomings of Massachusetts with respect to maintaining a system which is adequate for producing teachers qualified to manage the problems of the handicapped. My understanding is that our teachers colleges provide little or no opportunity for training of this sort.

This has been a longstanding deficiency. In addition, I know of no extra inducements salarywise for teachers to enter this field. I would not expect the number of such teachers ever to be very great in view of the special interest and aptitudes involved, but they are sorely needed at the present time and we must have more of them if our efforts to train and educate young folk with special problems are to be effective.

I have been at the Children's Medical Center for 8½ years. I have been continually upset over the fact, with all due respect to my New England friends in terms of neighboring States, that in the Boston area which at least until several years ago was usually considered as the medical center of the world, we have a number of various sources where we could provide inteacher training, but there is only one center, as has already been presented, which provides teacher training for the deaf in the New England area, which is the Clarke School for the Deaf, of course, in Northampton.

But here again, and if I may simply mention the fact, the Perkins School for the Blind is usually considered one of the finest schools for the blind in the world.

We have the Walter E. Fernald School for the Mentally Retarded. This is all in the periphery of Boston.

We have the Judge Baker Guidance Center for emotionally disturbed children.

We have the Horace Mann Day School for the Deaf.

We have fine centers in terms of Boston University and Emerson College. We have the facilities if we can only obtain the funds to initiate and to expand what is already there.

For this reason, gentlemen, I am here to support 494, and in terms of the fact that we have been talking about it for over 10 years, let us do something now.

Thank you.

Mr. GIAIMO. Thank you very much.

The next witness will be Edward J. Waterhouse, director, Perkins School for the Blind, Watertown, Mass.

STATEMENT OF EDWARD J. WATERHOUSE, DIRECTOR, PERKINS SCHOOL FOR THE BLIND, WATERTOWN, MASS.

Mr. WATERHOUSE. May I briefly introduce myself. My name is Edward J. Waterhouse, and I was born in England and educated at the University of Cambridge. I have been a resident of the United States since 1930 and a U.S. citizen since 1935.

I have been on the staff of the Perkins School for the Blind almost continuously since 1933, and its director since 1951.

I am a member of the legislative committees of the American Association of Workers for the Blind and the American Association of Instructors of the Blind.

I am a member of the Governor's Advisory Committee of the Massachusetts Division of the Blind, the president of the Massachusetts Association for Promoting the Interests of the Adult Blind, and a

member of the executive committees of various other organizations engaged in the education and rehabilitation of blind people.

I am also the secretary of the International Conference of Educators of Blind Youth, and have attended international conferences in Europe, Asia, and South America.

Since my appointment as director, I have been able to travel extensively, visiting over 70 schools for blind children in the United States and in 18 other countries.

Perkins was the first school for blind children to receive a charter in the United States. This took place in 1829 under the laws of Massachusetts.

Presently, the total enrollment is approximately 300 pupils. Special features of the school include the Howe Press, which embosses books and manufactures equipment; the Perkins Library, which is the regional library for New England of the Library of Congress; two teacher training programs, one for workers with the blind, and the other for workers with deaf-blind, both in association with Boston University; an extensive department of psychology and guidance, and the largest department of educating deaf-blind children anywhere in the world. This latter contains 29 children this year.

The following brief breakdown of our income is significant. These figures are approximate and are for the school year 1958-59:

From State sources:

Tuition	\$630, 275
Library services.....	12, 770
Total.....	<u>643, 045</u>

From private sources:

Tuition	87, 250
Interest on endowment.....	523, 235
Total.....	<u>610, 485</u>

From Federal sources:

American Printing House.....	8, 500
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I would like to draw your attention to the fact that Federal funds provided less than 1 percent of our income. The exact figure is 0.67 percent. Yet without the supply of books and other equipment provided from these Federal funds, our program could hardly have functioned at all.

It should be noted, however, that the equipment received on quota from Louisville was not, in itself, adequate, and the school paid approximately \$2,000 to its own Howe Press for additional material of this kind.

In the course of my extensive travels, I have found no Federal program in any country as effective in serving the needs of blind children as the program financed by Federal funds to provide books through the American Printing House.

As will be seen, the actual cost is not great. If we had to buy these services, it would not be a great tragedy, but if these services were not available at all, we would be in a very difficult position.

Without the Federal assistance which has helped to create the necessary organization it is difficult to see how these services could ever have been made available.

I presume, Mr. Chairman, that this committee will have to give consideration to the spending of further Federal funds in the service

of educating blind youth. I think that careful attention should be given to the very vast differences existing in the attitudes of our State governments as to what is desirable for their blind children.

Some States are offering services which would seem to be reasonably adequate. I am sure that any one of us could wish to do better, and none of us, I am sure, is entirely satisfied with what he offers.

We have pupils enrolled from about 25 of our 50 States. Most of the children who come from outside New England are deaf as well as blind. The education of each child in this group is extremely expensive, running to about \$9,000 a year.

Half of this cost comes out of our own resources, and the remaining \$4,500 is charged in tuition.

Some of the wealthiest States find difficulty in meeting this fee, while some of the poorer States meet it readily.

Mr. Chairman, if I have learned any one thing from my dealings with the various States, and from my travels both at home and abroad, it is that finding money is not the prime problem. Rather, it is that money is entirely secondary to the attitude of workers with the blind, where there is a willingness to provide a service, funds are almost always made available.

I do not believe that your 2-year study, valuable as it may be, can answer what is to me the most important question of all. This is: "Why do States offer services of such varying value to their blind children?"

While I am in favor of many of the proposals which are coming to you as a result of these hearings, I would believe that the most important step you could take would be for you to request the Department of Health, Education, and Welfare to encourage each State to evaluate for itself the services which it is offering to the blind boys and girls in its care.

I am sure that if the citizens of different States realized how poorly they compare in many ways with some of their neighbors, they would insist on providing comparable services. I am sure that every State would find that in some respect or other it does not compare with the best.

From the results of such self-evaluation each of us could see where he is lacking. I believe that the results of a well-structured study of this kind, adequately circulated, would provide results comparable in value, dollar for dollar, to those mentioned above in connection with the federally supported program of the American Printing House for the Blind.

I thank you for your kind attention.

Mr. GLAIMO. Thank you very much, Mr. Waterhouse.

The next witness is Rachel Baker, president of the National Organization for Mentally Ill Children, Fairfield County Chapter, Conn.

STATEMENT OF RACHEL BAKER, PRESIDENT, NATIONAL ORGANIZATION FOR MENTALLY ILL CHILDREN, FAIRFIELD COUNTY CHAPTER, CONN.

Mrs. BAKER. Gentlemen, you have heard a number of distinguished witnesses requesting an increase in financial aid to existing programs for helping handicapped people of various kinds.

My request is going to be rather unique. I do not ask for any increase or acceleration of service at all. I am going to speak about a

group of people who have no service whatsoever and you have a complete virgin territory in which you can begin and give assistance on a planned and coordinated scale.

I am speaking for the mentally ill children. I am the president of the Fairfield County Chapter of the National Organization for Mentally Ill Children.

The national organization is a group of parents and relatives of severely ill, mentally ill, children. Many of these children are ill from infancy. There are almost no facilities whatsoever either statewide or in the local community for their planned and coordinated care.

So I am going to request a few possible explorations of Federal assistance in order to begin a program for these children whom I look upon as the most neglected, the most forgotten in America.

Briefly, I will ask for the following:

That the National Government should, first of all, find out for us how many there are. There is no way at all to estimate. So I would request that the National Government provide some means to collect and provide statistics on the number of severely mentally ill children in the Nation.

I will now read a passage from the report of the White House Conference by our organization which says that:

Although the Biometrics Branch of the U.S. Public Service secures some information on State hospital services to children, and receives information from some voluntary inpatient and outpatient facilities, it is mandatory to institute a nationwide reporting system for all voluntary and public facilities serving the prepsychotic and psychotic child.

Now, if this were made possible it would offer only a very small reflection of the state of need since so many of the cases are hidden, so many of these children are in institutions not planned for their care.

For example, I believe in our State institution, excellent State institution for the mentally retarded in Connecticut, which is one of the outstanding in the Nation, there are 80 so-called autistics, that is non-verbal children mute through emotional reasons, who are there in an institution that is planned for the care and treatment of the mentally retarded.

So there are probably many hidden cases which then would have to be ascertained by some other means.

Now, a few States have recently passed laws providing that the public schools should offer special services and classes to emotionally disturbed children and eventually in those States where those laws will be implemented perhaps it will be possible to find out the number of children of school age who are mentally ill.

In that way we may perhaps estimate the number in the Nation.

But I feel that the first thing for which I would like to speak is that the National Government should set up some means to collect and provide statistics on the number of mentally ill children in the Nation and then that the national office should provide a program of planned and coordinated research.

Some research grants are now given by the National Mental Health Institute, but these are spotty.

That the National Government provide a program for planned and coordinated research aid to:

(a) Define this illness. The greatest possible confusion exists in regard to the definition of the illness.

(b) Determine its physiologic and other causes.

I understand there is great need for physiologic, biochemical, neurological research.

(c) Develop plans for prognosis and treatment. So we need Government aid for a planned and coordinated program of research.

Then, three, that the national office should provide for or aid in the gathering of information on pilot projects on an international scale.

The only work that has so far been done for these children has, in America, been done where the distraught parents got together, raised money, and provided some kind of pilot project.

We now have a number of such pilot projects on the eastern seacoast and some on the western seacoast, and these already offer an example of possibilities of care and treatment.

I understand that in other countries, Austria, I believe, and Switzerland, more has been done. So I think we need to study pilot projects in this virtually unentered field.

Number 5, I should like to suggest that the Government should disseminate information and give aid to inspire the States and the local communities to undertake coordinated care of these children. This care might include local day care centers, counseling and home help to give relief to the parents; summer camps, special public services.

The local community takes almost no responsibility at all for the severely mentally ill child. So I think a great deal of inspiration, guidance, and information is needed there.

Then we need State facilities. We need a study of the possibilities of not the creation of large State institutions where, perhaps by the situation that an institution exists, we lock the problem away from us and there it remains, but we need the centralized facilities so that these children who are locked off from the world already will not be locked away from the opportunity or remaining as near to their parents and to the conditions of normal family life as possible.

The field is great. We have no experts to present and everything that I have said is said from the point of view of only what the parents alone have experienced and found out up until now.

Thank you for letting me appear.

Mr. GLAIMO. Thank you very much, Mrs. Baker.

The next witness will be John E. Swan, president of the Clarke School Parents Conference, Northampton, Mass.

STATEMENT OF JOHN E. SWAN, PRESIDENT, CLARKE SCHOOL PARENTS CONFERENCE, NORTHAMPTON, MASS.

Mr. SWAN. Mr. Chairman, members of the committee, have you ever had the experience, while enjoying a TV show, of having the sound go dead. You know, then, how virtually impossible it is for most of us to watch faces and lip movements and be able to understand

what is being said. We may frantically seek another channel, or just give up for a better time.

Multiply this loss of sound situation to encompass the entire world of hearing, for this is what faces the deaf.

Lost to them, perhaps forever, is the beauty in the song of a bird, the ominous warning or the cheerful comfort in the crackling of a fire, the blended sounds of a great symphony, or the noise of an approaching automobile.

Also missing are even the little things such as the rustle of a newspaper as the pages are turned, the crunch of snow under one's foot, the purr of a kitten, or the ticking of a clock. Yet, thousands of children live in this kind of world.

Many of these children have never really heard sound. They cannot switch to another channel or give up for a more favorable time and situation. Indeed, they come to the realization that they are different and, much as they may wonder why, must try to cope with a predicament not of their choosing.

In deaf children, very often their problems may well stem from the one exceptionally characteristic of now being able to hear. This does not mean they cannot be happy, that they are not alert, that they are not intelligent or that they cannot lead independent, useful, and productive lives in a hearing society.

It does mean that there is a tremendous task for them to succeed, by way of a most difficult road.

Let me cite a few examples in respect to their education. For the deaf, it is a near impossibility to follow a group discussion, for they cannot know who will submit his view next.

Picture the difficulty, without the faculty of hearing, in trying to catch a question or comment thrown in when another has the floor. Or taken the normal educational practice of a lecture proceeding simultaneously with demonstration. Here visual concentration must be focused on one or the other, even if the educator does not turn his back or get behind his apparatus.

Or yet, the problem of taking notes. You and I can guide our writing by watching our paper and let our ears pick up the message. In the education of the deaf, teachers must recognize these and many other problems and adapt their methods accordingly.

In many respects one's education, personality traits, and interests in life are acquired by following the example of others. Young children learn to use their spoons, tie their shoes, put away their belongings, and so on, by watching members of the family. They pick up little mannerisms such as a wink or a nod or enjoy the same pursuits as their parents or other children.

All our senses—smell, sight, touch, taste, and hearing—seem to be aroused by the example set by others. This, very often, is poignantly brought home to the parents of deaf children while these youngsters are at a very tender age.

A child, born deaf or deafened in his first year, may imitate other children in many ways, particularly in play habits. Then, perhaps in the second year, as the parents anxiously await the first sound of speech, they suddenly sense that speech sounds are not being imitated

as are these other habits and expressions. This awakening may be their first indication that the child does not have normal hearing. The ensuing diagnosis as to the type of impairment and the degree of loss usually is beyond the average general practitioner of medicine.

There have been unfortunate cases where parents realizing their children cannot hear normally have not been guided to available experts in the field. Unless detection and complete diagnosis is made early, several years of valuable time to adapt the deaf child to the manner of his education may be lost.

Training in the home can make a start. Through correspondence courses and various societies or agencies working with those having hearing handicaps, the parents can lay a groundwork. With the deaf child, as with any child, the span of interest is initially very short. To maintain contact, there must be a mutual visual relationship.

You cannot call to the child to look at you, and if he wants to turn his head or close his eyes, there is little chance of getting his attention. This means repetition and patience, over and over.

Persistence eventually pays and the attention discipline or routine gains in effectiveness. One can proceed with learning by association.

Speech of the parent has very little meaning. The child's understanding starts by associating a lip movement or facial expression with an object, one he sees very often. Gradually his vocabulary of lip-reading gains headway. This goes on by adding new objects, playing games of recognition, and adopting similar tactics until you can broaden the child's understanding by having the objects represented in more than one way, like having a ball, a picture of a ball, the word "ball," or having balls of different sizes or colors.

Everything the child learns must be based first and foremost on establishing an understanding.

We parents are often impressed, particularly as the deaf child moves through the years of formal education, with how simple and fundamental this threshold of understanding still must be and how much repetition is required.

We tend to overlook that repetition plays a very similar role with the hearing child, but in that instance the contact is through the medium of speech and hearing. For with the hearing, this repetition is done far less consciously than to first establish visual contact as we must do with our deaf children.

As a child grows older, his thirst for knowledge increases even faster than his years. This must have means of expression. To most of us the means of expression is speech, which although not denied to a deaf child is certainly not readily acquired. Here is where the parent generally finds himself quite inadequate. Here is where we must turn to specially trained persons to forward the education of our deaf children.

There is vastly more to speech than just pitch or volume. I speak of breath control, position of the tongue and the lips, resonance in the throat or nose, and rhythm. Many of these elements of speech are not visual, the child simply cannot acquire the ability of speech by watching others. Speech imitation is largely restricted to the hearing. One small example is found with the words "red" and "green." To us,

these seem very distinctly different. But I ask you to try to say before a mirror the words "red" and "green" with no sound.

You will find the visual image very similar and if not carefully spoken could be misinterpreted by a deaf person who must rely on lipreading.

There are numerous other examples. Many sounds have no visual expression. To educate the deaf to speak means they must consciously memorize perhaps several distinct parts of making even a simple sound, such as an E or an R.

Patience for repetition and a firm understanding of speech fundamentals become ever so much more important for the teachers of the deaf than for those teachers training hearing children. For those teaching the deaf, we parents have only admiration and respect. Theirs is frequently a life of devotion, filled with many heartaches and frustrations. It has also its joys, hard won, but rewarding, as when a small face lights up with the thrill of understanding.

I hope, through this view of a parent, you have gained a bit more insight into the problems of teaching deaf children.

We feel that any Federal action to encourage more persons to become teachers of the deaf will benefit society and the welfare of this country.

This year our parents group membership comes from 20 of the States, plus the District of Columbia and Canada. Within Massachusetts, some 69 different cities and towns have at least one set of parents represented.

To interpolate these educational needs to embrace the entire United States, considering our parents' group is affiliated with but a one school, only emphasizes the salient points brought out in House Joint Resolution 494.

In behalf of the Clarke School Parents' Conference, and parents of deaf children anywhere, I have been pleased and proud to present my views and sincerely support any efforts to see this legislation be favorably acted upon in the next session of Congress.

Thank you.

Mr. GLAIMO. Thank you very much.

Mr. SWAN. Mr. Chairman, I should like to offer the addendum I have of the details of cities and towns of Massachusetts with my statement.

Mr. GLAIMO. Without objection, the information will be made a part of the record.

(The addendum referred to follows:)

ADDENDUM

The Clarke School Parents' Conference is comprised of parents of deaf children from:

Canada	Michigan	South Carolina
Colorado	New Hampshire	Texas
Connecticut	New Jersey	Vermont
Delaware	New York	Virginia
District of Columbia	North Carolina	Washington
Georgia	Ohio	Wisconsin
Maryland	Pennsylvania	
Massachusetts	Rhode Island	

Detail of Massachusetts cities and towns:

Agawam	Holyoke	Revere
Amherst	Indian Orchard	Roslindale
Attleboro	Ipswich	Saugus
Auburn	Leominster	Scituate
Belchertown	Lexington	Somerville
Bernardston	Longmeadow	South Gardner
Braintree	Lynnfield	South Hadley
Brookline	Mattapan	South Hadley Falls
Carlisle	Medford	South Hanover
Cataumet	Milford	Southwick
Chicopee Falls	Millbury	Springfield
Dedham	Montague	Swampscott
Dorchester	Newton Highlands	Templeton
Dracut	North Adams	Ware
East Longmeadow	Northampton	Webster
East Natick	North Attleboro	West Newton
East Pembroke	North Billerica	Westover AFB
Fall River	North Pembroke	West Roxbury
Falmouth	North Scituate	West Springfield
Fitchburg	Palmer	Williamsburg
Florence	Phillipston	Willimansett
Granby	Pittsfield	Winchester
Hatfield	Quincy	Worcester

Mr. ELLIOTT. We have reached the point in our proceedings here this afternoon that we must recognize those who have been engaged in the workshops.

First, may I introduce Dr. Elena D. Gall, assistant to the director for field studies.

We have been conducting in Washington and about the country for a period of several months now a special education and rehabilitation study under the direction and the overall supervision of this sub-committee.

Dr. Gall will tell us about the part of the study, the workshop, that has been conducted here in New Haven. She will present the representatives of the workshop groups.

Dr. Gall.

**STATEMENT OF ELENA D. GALL, ASSISTANT TO THE DIRECTOR
FOR FIELD STUDIES, SUBCOMMITTEE ON SPECIAL EDUCATION,
COMMITTEE ON EDUCATION AND LABOR**

Dr. GALL. Mr. Chairman and members of the committee, the Special Education and Rehabilitation Study Committee has been for 2 days deliberating on the unmet needs in special education and rehabilitation which is the function of your subcommittee, and we have been able to do this with the help of approximately 235 representatives of all of the New England States who in turn represent over 100 private and public agencies who are interested in at least seven areas of exceptionality.

Most of our participants have come and paid their own way and given freely of their time.

I heard the story last night of a dedicated school administrator who had used her Christmas Club money to pay for the expenses of the trip. But it is in this spirit that the people of New England have answered to the call of your subcommittee, Mr. Chairman, and have responded, as you have, to the needs of the handicapped individuals in the New England region who are not yet being treated or cared for at this time.

It gives me a great pleasure to say that the New England regional workshop has reached a new height in the quality of workshops on the subject of the unmet needs of the handicapped.

Perhaps it was because of the surroundings. In the great university of Yale we felt that only top quality thinking and contributions would do at this time and we are indebted to Mr. Giaimo and Miss Hartman for having made such excellent preparations.

Mr. Chairman, if you will call the representative of each workshop according to the title of their workshop, the chairman or representative of that group will come up and introduce himself and present the deliberations of that group.

Thank you.

Mr. ELLIOTT. Thank you, Dr. Gall.

First, we have the speech hearing group, William A. Philbrick, Jr.

**STATEMENT OF WILLIAM A. PHILBRICK, JR., SUPERVISOR OF
SPEECH HANDICAPPED, HARD OF HEARING, AND DEAF DEPART-
MENT OF EDUCATION, COMMONWEALTH OF MASSACHUSETTS**

Mr. PHILBRICK. Mr. Chairman, my name is William A. Philbrick. I am State supervisor of speech handicapped, hard of hearing, and deaf department of education, for the Commonwealth of Massachusetts.

I have heard that there are three types of persons who read manuscripts. The one type very carefully takes each page, puts it aside, lifts the next page, puts it aside, in good order, and you can measure his progress down to the bottom of the heap.

The second one picks up the first page and reads the front of it and then turns it over and reads the back of it and this is not as optimistic, but still progress can be measured down to the bottom of the heap.

And the third and most reprehensible kind is he who takes each sheet and carefully reads it, puts it aside, until he has reached the bottom of the heap and then picks it all up and turns to the back side and starts to read the back side again.

Well, we shall not do this. Those of us in the field of the speech handicapped, hard of hearing, and deaf would not do it especially because we are intensely conscious of a factor in our field that is known as auditory fatigue. This is something that happens from constant drumming upon the eardrums of some kind of sound stimuli.

So to help prevent that we will not even take all of the 10 minutes so graciously allotted to us, but instead rest confident upon the report, a copy of which we should like to enter into the record.

We feel that all of us have worked very hard for 2 days and that this report really is the culmination of all our professional wisdom and we confidently entrust it to you, to your professional wisdom and knowledge of the arts of government and the needs of the national picture, with only this brief summation to structure it for you, based on two items:

The one is the number of persons needing speech and hearing therapy and education as deaf persons in New England, based on a nationally accepted incidence figure, and,

Two, the present state of the training programs, the training institutions, and the numbers of students wishing to be trained.

As far as New England is concerned, over one hundred thousand children, based on a national incidence figure, need speech and hearing therapy and thirty thousand are getting it.

The one hundred thousand figure would need twelve hundred and twenty-seven trained speech and hearing therapists to give the kind of care required in the public schools alone.

We have actually 198 such speech and hearing therapists.

The problems in the field of the deaf are equally as serious. Teachers are needed and have been needed for over 10 years in that area.

We turn, then, to our source of supply, the training programs and training institutions, and find that the five excellent training institutions in speech and hearing therapy in New England will turn out in June 50 speech and hearing therapists to meet that need of 1,027 and many of those will not stay in New England.

Therefore, you can see we have listed needs for funds in the form of grants-in-aid, in the form of scholarships, in the form of fellowships, in the form of incentive rewards to States to set up particular programs for speech and hearing, to rural areas to waken persons in rural areas to the needs of their own children and their own adults, and to waken preschool parents and adults to their own needs and the fact that they can be supplied if action will be taken.

The figures that we have used are as basic as we can get. The amounts of money we have quoted we have quoted as we see the need, knowing full well when the time comes you will adjudicate these amounts as you see fit in the interest of the national picture.

Speech and hearing presents its case in this report and hopes that you will deal kindly with it.

Mr. DANIELS. Mr. Philbrick, in this report have you set forth the five training centers?

Mr. PHILBRICK. The five training centers, yes, sir, and the number they turn out and the needs they would have this year for faculty and staff and equipment and in 1965 for faculty and equipment on the road to meeting the need now and in 1965.

Mr. DANIELS. Thank you.

(The report referred to follows:)

WORKSHOP REPORT ON THE SPEECH AND HEARING HANDICAPPED

Workshop meetings on Speech and Hearing Education and Rehabilitation held at Yale University, New Haven, Conn., December 15 and 16, 1959.

Cochairmen:

Dr. Geraldine Garrison, Supervisor of Speech and Hearing, State Department of Education, Connecticut.

Dr. Albert T. Murphy, Professor of Speech Pathology and Audiology, Boston University, Boston University.

Corecorders:

William A. Philbrick, Jr., Supervisor of Speech Handicapped, Hard of Hearing, and Deaf Department of Education, Commonwealth of Massachusetts.

Dr. Wilbert L. Pronovost, Director, Speech and Hearing Center, Boston University, Boston, Massachusetts.

Workshop participants:

Joan Allen, speech pathologist, Portsmouth Rehabilitation Center, Portsmouth, N.H.

Hilda F. Amidon, supervisor of speech and hearing services, Board of Education Hartford, Conn.

David P. Barron, supervisor, speech and hearing clinic, Southbury Training School, Southbury, Conn.

Edmund B. Boatner, superintendent, American School for the Deaf, West Hartford, Conn.

Norton Canfield, Yale University School of Medicine, Connecticut State Medical Society.

Alan G. Crouter, superintendent, Mystic Oral School for the Deaf, Mystic, Conn.

Pauline Ehrlich, assistant in charge, lipreading classes, Boston public schools.

Dennis Ellsworth, board of education, public schools, Fairfield, Conn.

Estelle E. Feldman, director of pupil services, department of education, New Haven, Conn.

Herbert J. Gavilli, same as counselor.

Inez E. Hegarty, chairman, Department of Speech and Hearing, University of Massachusetts.

Martha E. Jones, speech and hearing clinician, New Britain public schools, New Britain, Conn.

Grace M. Kennedy, speech and hearing counselor, Newton public schools, division of counseling services, West Newton, Mass.

Helen MacPherson, hearing consultant, public schools, Providence, R.I.

Edmund G. McLaughlin, executive director, speech and hearing clinic, Bridgeport, Conn.

Julian Perlstein, counselor, State Bureau of Vocational Rehabilitation, Hartford, Conn.

Catherine C. Perry, chairman, Department of Speech Pathology and Audiology, Emerson College, Boston, Mass.

George T. Pratt, principal, the Clarke School for the Deaf, Northampton, Mass.

Frances Roberts, Connecticut State Department of Mental Health, West Hartford, Conn.

Harred Saleh, director of speech and hearing, 68 Earl Avenue, Hamden, Conn.

Josephine E. Setterberg, senior speech and hearing consultant, West Hartford Board of Education, 7 Whiting Lane, West Hartford, Conn.

Adam J. Sortini, director, hearing and speech clinic, Children's Medical Training, Boston, Mass.

Jane F. Stapleton, social worker, Boston Guild for the Hard of Hearing.

Theona S. Sutay, supervisor of speech and hearing, Bridgeport, Conn., supervisor's office, Hall School, Claremont Avenue, Bridgeport, Conn.

SPEECH AND HEARING

I. Incidence

A. Great need for intense research to identify the types and geographical distribution of speech and hearing problems and deafness. This need implies the necessity of wholehearted cooperation among agencies of all kinds to accomplish the desired result.

B. Factors involved in the production of diverse incidence figures are:

1. Lack of standardized criteria to delimit types of problems.
2. Listing minor degrees of problems as major.
3. Geographical location of speech or learning handicapped persons.
4. Degrees of training of persons in diagnostic or educational centers.

C. The American Speech and Hearing Association estimates of incidence are:

	<i>Percent</i>
Speech handicapped.....	5
Hearing handicapped.....	3
Severely hearing handicapped.....	7

D. There is a need for Federal support of a law requiring registration of persons with speech and hearing problems.

E. Pertinent data:

1. *Connecticut data.*—The White House Conference estimated that 5 percent of the school population have speech and hearing handicaps. This report on status and needs in Connecticut is based on this 5 percent prediction: 22,885 children in Connecticut public schools have speech and hearing problems; 35 percent or 8,000 (approximate) children are now receiving speech and hearing in Connecticut public schools; 65 percent or 14,875 could benefit were such services available; 80 speech teachers now provide services for the 8,000 children; 150 additional speech teachers are needed now to provide services for the 14,875 children on the ratio of 100 children to each teacher. In most Connecticut schools the speech teachers work with from 60 to 90 children, not 100 children; 10 additional speech teachers are needed now to meet speech needs of the mentally retarded children.

Thus 160 additional speech teachers are needed now in Connecticut public schools. This does not include the 3,965 children who could benefit from speech and hearing services were such services available in parochial schools. An additional 40 would be needed to work with children in parochial schools. Fourteen positions are now unfilled as a result of resignations. Four speech teachers coming into Connecticut schools in September 1959, were trained in Connecticut.

1965-66: 5,767 additional children will need speech and hearing services in 1965, 58 additional speech teachers will be needed to work with these 5,767 children in 1965; 20 additional speech teachers will be needed to work with mentally retarded children in 1965.

Thus 318 speech teachers will be needed in Connecticut public schools in 1965; 70 additional speech teachers will be needed in parochial schools in 1965; total, 388 speech teachers will be needed in public and parochial schools in 1965, 308 more than in 1959. Where are they coming from?

SCHOOL FOR THE DEAF, 1959-60

Sixty-four percent increase in enrollment at one school for the deaf (Mystic) during the past 6 years. Present enrollment 139: 27 children are on the waiting list because of lack of teachers; 9 classroom teachers are needed now and cannot be found; 4 special teachers are needed now: supervising teacher, librarian, 2 physical education teachers; 2 house mothers are needed to maintain a ratio of 1 house mother to 10 children; 1 audiologist is needed for hearing evaluation of pupils upon admission and for systematic retesting and for advice in fitting of hearing aids; 1 psychologist is needed for adequate psychological testing.

2. *Massachusetts data* (1E).—50,000 children in Massachusetts public schools have speech and hearing problems; 34 percent or 17,200 (approximately) children are now receiving speech and hearing therapy in Massachusetts public schools; 66 percent or 32,800 could benefit if such services were available; 100 therapists now provide the services for the 17,200 children; 320 additional speech teachers are needed now for the 17,200 children (100 children to each teacher); 90 speech teachers are needed to meet the needs of mentally retarded children (educable); thus, 410 additional speech teachers are needed now in Massachusetts public schools. This does not include the more than 5,000 parochial school children who need these services.

1965-66: 12,500 additional children will need speech and hearing services; 125 additional speech teachers will be needed for them; 25 additional speech teachers will be needed for the mentally retarded;

Thus 660 speech teachers will be needed in the Massachusetts public schools in 1965.

DEAF

Six hundred seventeen Massachusetts children are presently attending residential schools, day schools, or day classes for the deaf. These children attend the Beverly, Boston, and Clarke Schools for the Deaf—residential schools; the Horace Mann School—day school; six day classes in public schools; and the Rhode Island School for the Deaf in Providence, R.I., Austine School in Brattleboro, Vt., and American School for the Deaf in Hartford, Conn. Perhaps 5 percent of the deaf children are emotionally disturbed or mentally retarded to such a degree as to render placement in a regular school or class for deaf impossible. There is no source of education for them at this time.

Federal assistance is needed to provide trained personnel in institutions for disturbed and retarded children so as to assist these children in the development of language and communication.

OTHER NEW ENGLAND STATES

	Need therapy now	Teachers needed now	Increase in cases by 1965	Number extra teachers needed by 1965
Maine.....	9,500	95	2,380	24
Vermont.....	3,700	37	925	9
New Hampshire.....	5,650	57	1,450	15

NOTE.—Much of the work in these States and in Massachusetts, Rhode Island, and Connecticut towns of less than 5,000 population will have to be done on a regional basis. This does not take into account all the clinical, hospital, college, university, and private practice speech and hearing therapists needed in the States.

II. *Extent and kinds of present services and facilities for diagnosis, education, and guidance and need of better services and facilities.*

A. Massachusetts, Maine, New Hampshire, and Vermont need State reimbursement programs for speech and hearing in the public schools.

B. Private schools need Federal aid for speech and hearing programs.

C. Approximately 50 percent of mentally retarded children need speech and hearing therapy.

D. Different States have different needs. This implies need for a coordinating body or individual in each State as well as the whole region.

E. Perhaps a regional diagnostic, education, and treatment center is the answer for the child with a complicated language disturbance. The cleft palate team at Tufts needs to be duplicated or to travel—perhaps pilot programs are needed for selected groups (preschool, geniatics).

F. Although the public schools own teams can do diagnosis and therapy with many multiple-handicapped children—and ought to be encouraged to do more—the severely multiple-handicapped child is often not served.

G. We need intensification of preschool diagnostic and treatment facilities; means of doing counseling at home; the use of written materials for parents and children; extension of social work services to these families. Pilot nursery school programs should be set up. Increased guidance services should be made available to the adolescent and adult speech hearing handicapped and deaf populations. Federal funds to assist in the creation of units like the Sarah Fuller Foundation, sending trained teachers of the deaf into the homes of hearing handicapped infants to help the parents understand the problem and when appropriate to begin the teaching of language and communication to the child.

H. Provision must be made for family followup work by school social workers and guidance.

I. Funds to facilitate better screening of speech and hearing handicapped infants by providing grants for training of pertinent personnel.

J. Funds to provide two annual 6-week workshops to upgrade personnel presently functioning in speech and hearing and education of the deaf—these workshops to invite 25 to 30 persons from the region and to cost approximately \$30,000 each.

K. Meeting the needs of private and parochial school populations as well as the children with severe speech and hearing problems by operating summer school speech and hearing programs and by assisting the creation of summer day and residential camps for speech handicapped, hard of hearing, or deaf children.

L. Speech and hearing personnel and coverage in Office of Vocational Rehabilitation and State outlets should be amplified.

M. Education, information, and reciprocal assistance must be effected with guidance personnel, psychologists, medical personnel, nurses, and other allied individuals by means of institutes, workshops, and conferences.

N. Federal assistance is necessary to increase existing physical plants because of pressure of increasing caseloads, required personnel, and new equipment. However, lack of data on types and degrees of problems, cerebral palsy, aphasia, etc., prevents pertinent proposals for sizes, teachers, and equipment needed. (Massachusetts Eye and Ear—300–400 outpatient cases annually; Children's Medical Center, 2,000 cases annually.

O. To meet the problem of facilities in rural areas for speech handicapped, hard of hearing, and deaf persons, the following procedures are necessary:

1. Federal funds to be made available to departments of education to launch intensive information campaigns to create an awareness of the existing problems and the assistance required.

2. Utilization of summer camps for speech and hearing handicapped or deaf persons to demonstrate size of problem and techniques for coping with it.

3. Federal assistance in creating regional public school speech and hearing programs as well as regional diagnostic, educational, and treatment centers.

4. Federal funds for transportation, board, and diagnostic and therapeutic fees for children and adults visiting regional diagnostic medical centers for speech and hearing examinations.

5. Pooling of speech and hearing resources with those of other rehabilitation and education facilities to create centers offering wide services.

6. Federal funds to explore feasibility of and provide materials for—

- (a) Utilization of homemakers extension services in State departments of agriculture, Grange organizations, farm bureau, 4-H clubs, and other farm community clubs to publicize the existence of speech handicaps, hearing loss, and deafness, and to educate rural populations in the types of diagnostic and therapeutic services indicated.

- (b) Requesting assistance of the visiting nurses associations for similar informational purposes—providing mobile testing units and recording units at county fairs to spread awareness of the existence of facilities and the need for same.

P. Extension and amplification of services to the homebound by providing fees for speech and language retraining of adult aphasics at home or in nursing homes.

Q. Need for more extensive services and assistance to speech handicapped, hard-of-hearing, and deaf persons through State rehabilitation offices, with prostheses for cleft palate problems and hearing aids for hearing handicapped supplied at minimal cost, 25 percent, by the Government.

R. If funds could be made available to employ an instructor, methods and techniques for preparing persons to do pure tone threshold hearing testing together with information on hearing conservation could be provided through a concentrated 2–3 week workshop held in different sections of the State. Of necessity enrollment in such a workshop should be kept small. An estimated 300 school nurses and other persons would attend these workshops. The workshops could be conducted in a local school, a school for the deaf, a State college or the university at a nominal cost. The benefit to children with suspected hearing losses would be of great significance in both time and money.

S. There are many children with minor speech and voice difficulties which could be corrected in the speaking activities in the classroom if classroom teachers had basic preparation in speech improvement. This preparation in speech improvement could be provided classroom teachers through (1) college courses at the college or at the local level or (2) workshops held at the local level or on a regional basis. The equivalent of three college courses would give the needed preparation in speech improvement. The Federal Government could

help by making available the financial assistance necessary to provide the college courses or workshops. The cost would not be great, but could include the cost of tuition or the fees of the instructor at the workshop.

III. Personnel and training facilities

A. There is great need to increase the training facilities for teachers in the field of the speech handicapped, hard of hearing, and deaf. This necessitates amplification of staff and facilities in training centers as well as scholarships, fellowships, and upgrading of present personnel.

We now have 193 speech and hearing teachers in the public schools of New England. On the nationally accepted incidence of 5 percent of the school population having speech and hearing problems, and the nationally accepted ideal of 1 speech and hearing teacher per 100 children, we actually need 1,027 such teachers to serve all the speech and hearing handicapped children needing help. We desperately need at least 260 of the 1,027 teachers immediately.

Office of Vocational Rehabilitation has estimated that for the preschool and adult populations (school population excepted) one speech pathologist and audiologist per 50,000 persons is required. On this basis, New England needs 200 such clinicians at this moment in its hospitals, clinics, and private agencies, but has no more than 50. At least 50 more of the ideal 200 are needed immediately.

B. In the field of the deaf in New England in 1958-59 classroom teachers were needed. Only 118 were trained for the whole country with 516 openings.

In 1959-60 new teachers were needed. Only 127 were trained for 511 positions. One hundred and sixty-one are now training nationally but five centers have no students at all. Scholarships are badly needed now; higher salaries are needed soon.

C. At this moment four New England teachers are training for the deaf at Clarke. Ten graduate students in speech and hearing will soon graduate from South Connecticut College. Eighteen students will graduate in June from Boston University. Thirty students will graduate in June from Emerson College. Seven students will graduate in June from the University of Connecticut.

These small numbers (4 teachers of the deaf, 65 speech and hearing teachers) indicate an overwhelming need for a concerted recruitment program. American Speech and Hearing Association should be given a Federal grant to do a national recruitment program in all our fields. With this should be an information program, public relations program, and an organized drive for upgrading present personnel.

D. Extension courses and clinical demonstrations must be used to create accessibility of training.

The increase in numbers of therapists and teachers of the deaf would require more supervision, therefore more supervising help, therefore more staff and much greater expense. Among the schools for the deaf even supervisory and administrative staff are in very short supply because of the duration of the teacher shortage. Federal assistance is badly needed here.

The numbers of hospital, clinic, and private agency positions receiving speech and hearing clinicians of the educational rank referred to as speech pathologists or audiologists indicate the need of expanded training programs qualified to train people to this high level. The course requirements, necessary staff, equipment, and supervision would necessitate double or triple the personnel and budgets now obtaining in training institutions.

F. No audiologists are being trained at this moment anywhere in New England. The gravity of this situation cannot be overemphasized.

G. The present crippling caseloads being borne by speech and hearing therapists in most parts of New England probably preclude the possibility of really successful therapy with most of their cases. This overwhelming amount of work may also cause young therapists to leave the profession.

H. There is a great need of Federal aid in the form of reimbursement for part of the salary of new personnel in speech and hearing and education of the deaf at the State level, in public or private schools, hospitals or clinics, or in the form of reimbursement for expansion of existing programs of speech and hearing or education of the deaf.

I. There is needed a minimum of \$500,000 annually for 5 years in the form of grants-in-aid and fellowships to expand existing training programs and to facilitate the creation of new training programs in the fields of speech and hearing and education of the deaf.

J. The present lengthy practicum requirements of 1 residential year for teachers of the deaf, and the growing tendency to increase the length of practicum programs in speech and hearing—thus implying the need of 5-year and 6-year training programs—indicate clearly the need for Federal funds to facilitate the assumption of such practicum programs by students in speech and hearing and the education of the deaf.

K. The Federal Government should rescutinize the provisions of the Social Security Act of 1936 relating to assistance to persons in depressed, rural areas. In many cases today the population explosion has carried the better class city folk out into the rural areas, thus raising this socioeconomic level, and has left the city a much depressed area. New lines and provisions must be drawn to take cognizance of this shift.

Funds should be available for persons in local or State supervisory positions in schools, hospitals, clinics, or agencies to pursue such extra training as will bring them the advanced certification befitting their responsibilities.

IV. Research needs

A. Intensification of incidence studies by type, age, and geographical distribution.

B. Comparison of educational and treatment approaches—especially for the retarded and physically handicapped.

C. Many studies on adolescent speech and hearing problems—a barren area.

D. Analysis of transition between school and work—correlation between guidance personnel and rehabilitation agencies.

E. Incidence by type and age of persons attending clinics and agencies not accounted for in other data.

F. Value of temporary sheltered employment and training for persons with severe speech or hearing handicaps.

G. Better prognostic methods with adults having severe speech and hearing problems.

H. Kinds of facilities best adapted to rural versus urban population (central versus dispersed, etc.).

I. Need of laboratories to study the psychophysics of audition and the speaking process.

V. Pressing financial problems working against more effective service

A. Source of tax moneys may have reached peak—city property can yield little more. New traffic patterns of funds must be found.

B. Salaries of regular school teachers cannot be met by schools for deaf initially or for maxima. This cripples recruitment. Same for institutions for mentally retarded.

C. Shortage of young male teachers indicates that salaries are not sufficient to support a family.

Mr. ELLIOTT. Thank you very much, Mr. Philbrick, for your testimony.

Next, the group that worked on mental retardation.

STATEMENT OF HELEN F. FREEMAN, COCHAIRMAN, WORKSHOP COMMITTEE, MENTAL RETARDATION

Miss FREEMAN. Mr. Chairman, I am Helen Freeman—

Mr. ELLIOTT. Now, Miss Freeman, let me say this to you: You speak as loudly as you can because some of our folks tell me that they are having difficulty understanding what is said. We think this is one of the very fine parts of our hearing here and we want everybody to have an opportunity to hear you. So you speak as loudly as you can, please.

Miss FREEMAN. Thank you, sir.

I am in good voice; I am sure I can make myself heard.

As my colleague Mr. Philbrick has suggested, we will be brief. We are not telling you how and so forth; we are simply suggesting what needs to be done. We are very grateful to your committee because so

far as we know, at least within our own lifetime, this is the first chance that all of the people in New England have gotten together to discuss these unmet needs in this situation.

We have all kinds of groups, professional and lay, private and public, political and just citizens, to discuss the problems. Some of the things we are going to present to you perhaps are particularly indigenous to New England; but, since we are an area that represents perhaps sections of all the rest of the country, we think that our findings are significant.

The other point is that in the past and with our long programs of education and other fields, which have been continuing, there have been times when we have not been in agreement, but within this 2-day session we have come to a unanimous agreement on the points that I am going to make to you.

To explore just a bit further why I say we are a good representative group, we do have these five things:

First of all, we have concentrated masses of population.

Secondly, we have a wide divergence in service development.

Three, we have varied degrees of State and local participation and development.

Four, we have multiracial and social groups.

Five, we have varied economies.

This is most important, both agriculturally and industrially.

In other words, we represent urban populations and rural populations.

The last one, perhaps, is ours. The traditional New England reluctance to seek aid outside her own boundaries and the rugged individualism so characteristic of New England since the days of the Founding Fathers—in other words, much of what we have done to date we have done on our own.

These are the areas in which we suggest that you can help:

First, then, we would suggest to you that we have a national census of the population of people who are retarded.

We would suggest that, late though it may be, if you could incorporate a couple of leading questions in your 1960 national census that might be of help. Otherwise, in some feasible way.

To date we have no national census as to the approximate numbers of these people. After all, our determinations of needs relate themselves to numbers so far as staff and budgetary requests are concerned.

No. 2, diagnostic services. We would like to suggest that you expand your program of grants-in-aid to make available to hospitals that are approved by American Hospital Association, to these hospitals that have pediatric services, funds for the provision of counseling and diagnostic services to the mentally retarded and their families and that to disburse these funds, you set them up in an equitable distribution.

We are all in agreement that the early diagnosis, the early recognition of these children will make the program for all of the mentally retarded a much better one.

The third point we make has to do with education of personnel and training facilities. I am referring here to this wonderful Public Law 85-926. The fellowships awarded there are fine and we want them to continue, but we would make two further recommendations:

No. 1, that you expand to include more than the 14 colleges or universities already mentioned.

May I insert here we don't have one in New England. We would like that.

The second point is that you include in some way your grants to the teachers in special education.

Actually, in New England, we agree that the dearth of specially trained teachers is jeopardizing continued progress in the fulfillment of the need of the retarded.

Our fourth point has to do with homebound and sheltered services and I will read this quickly:

Be it resolved, That the Federal Government institute a program to facilitate the development of adequate services to the mentally retarded in the following categories:

One, those who are preparing for sheltered workshop and/or vocational rehabilitation service.

Two, those currently homebound, but potentially able to participate as active members in the community to some degree.

Three, those currently in institutions who through such services as indicated may be returned to their homes.

We feel that this area of help for the older retarded is one of our areas of most crucial need.

The fifth point, more direct services to children and client.

I am here referring to Mr. Philbrick's suggestions on speech and hearing. These new provisions are fine. Those of us in the field of mental retardation only hope that some of the people who are going to do this work will be cognizant of the need of the retarded as we are concerned with speech and hearing problems.

No. 6. I generally call family services. Here we are suggesting that the maternal and child health grants of the Federal Government not be limited to public health departments, but, rather, that they be given over or assigned to any agency, public or private, which the State suggests.

Here we are thinking in terms of the development of day care services, not just for the young, but for the older retarded who can fit into any other area; for those retarded who require specialized care not now generally available, specialized dental services and training programs for dentists who can provide these.

The amendment of the Hill-Burton Act to enable the construction of special medically and therapeutically oriented facilities for the defective delinquent, recreational programs as a supplement for those who have no other place in society, as a supplement to day care activities, education, rehabilitation, residential care, and as a common activity for those who can participate in no other organized program.

For additional research and increased budget for wider distribution of health information aimed at reducing birth defects.

We feel if the information we already have were disseminated perhaps 25 to 40 percent of the defects that are occurring at birth could be eliminated.

For improving prenatal care, pediatric care and child health supervision. That additional funds be made available for increased field services of the Federal agencies concerned with the implementation of programs for the retarded.

Very simply, we need grants for schools in New England very badly.

That, in essence, is what we have come up with.

Conditions and the situations are not particularly isolated in any one area in New England, but I am presenting to you four or five problems which are common to all of us here.

Once again, thank you very much for hearing me.

Mr. ELLIOTT. Thank you, Miss Freeman.

Did I understand that your workshop group was unanimous on this report?

Miss FREEMAN. Yes, and that is unusual for us.

Mr. ELLIOTT. That is unusual, it certainly is.

(The report referred to by Miss Freeman follows:)

REPORT OF WORKSHOP ON MENTAL RETARDATION FOR THE NEW ENGLAND AREA,
YALE UNIVERSITY, DECEMBER 15, 16, 1959

The representatives of the New England States here assembled to discuss unmet needs in the field of mental retardation wish to express our gratitude to the congressional Committee on Education and Labor and especially to the subcommittee on Special Education for the opportunity afforded us through this workshop. This experience, we feel, has been unique both from our point of view and yours. For us, it is the first opportunity ever presented where representatives of local and State agencies, lay and professional organizations, public and private agencies have met to articulate and synthesize the needs in mental retardation of the entire New England region, with relation to assistance which might be offered by the Federal Government. For the committee, we believe, you have introduced to this field a new technique of investigation, where the overworked term "grassroots" has taken on a real meaning.

We believe that this approach will be most fruitful to the Congress, to the Federal Government and to the people you serve. While we have special interests and consideration for the needs in the field of mental retardation, as New Englanders we are most anxious to determine that any program which is undertaken will be a sound investment for the Nation, based on actual, articulated needs, not intuition, and evolved in workable fashion so that it will bear fruit in the habilitation or rehabilitation of the largest possible numbers of the handicapped individuals we seek to serve.

Certain problems in the field seem to be indigenous to New England, but the fundamental basic needs in mental retardation are probably reflected nationally by the conditions we found—

1. Concentrated masses of population.
2. Wide divergence in service development.
3. Varied degrees of State and local participation and development.
4. Multiracial and social groups.
5. Varied economies, both agricultural and industrial.

6. The traditional New England reluctance to seek aid outside her own boundaries, and the rugged individualism so characteristic of New England from the days of the Founding Fathers.

In its deliberation the committee has addressed itself not to the writing of new legislation as such, but has oriented itself to the needs of the mentally retarded and their families in both urban and rural areas; nor has the committee directed itself to isolated conditions but has concentrated on universal needs.

Only a few years ago, professional people of all disciplines working with the retarded were of varied opinions as to the needs, care, treatment, management, control, rehabilitation, guidance and followup of the retarded. There was even disagreement as to the techniques required to achieve these goals for the retarded.

A striking characteristic of the deliberations of this committee, composed as it was of representatives of virtually every discipline concerned with the problems of mental retardation, was the unanimity of opinion which emerged concerning the following recommendations:

CENSUS OF RETARDED POPULATION

Be it resolved, That the Federal Government undertake a national census, for the determination of our retarded population at its earliest convenience, if possible, within the framework of the 1960 general census, or by whatever feasible means, since the projection of future needs depends on explicit knowledge of the numbers to be served. Determination of needs relate themselves to staff and budgetary requirements.

DIAGNOSTIC SERVICES

Be it resolved, That the Federal Government, through an expanded program of grants-in-aid, make available to hospitals, which meet A.H.A. standards and have pediatric service, funds for the provision of counselling and diagnostic services to the mentally retarded and their families; that these funds be disbursed through a formula based on equitable distribution. Early diagnosis and continued evaluation are essential to the formulation of a life plan which will give every child an opportunity for optimum development (provided that we offer a total service program).

EDUCATION PERSONNEL AND TRAINING FACILITIES

Be it resolved, That the Federal Government continue the benefits derived under Public Law 85-926, but that the law be amended to enable the fellowships provisions provided therein to be applied to any teacher training institutions which are accredited to grant graduate degrees in special education, in addition to those institutions already listed under the law.

Be it resolved, That the Federal Government institute a program for undergraduate scholarships to students at any accredited teacher training institution and are studying in or specializing in the area of mental retardation.

The dearth of specially trained teachers is now jeopardizing the continued progress and the fulfillment of the needs of the retarded.

HOMEBOUND AND SHELTERED SERVICES

Be it resolved, That the Federal Government institute a program to facilitate the development of adequate services to the mentally retarded in the following categories:

(1) Those who are preparing for sheltered workshop and/or vocational rehabilitation services.

(2) Those currently homebound but potentially able to participate as active members in the community to some degree.

(3) Those currently in institutions who, through such services, as indicated may be returned to their homes.
Our committee unanimously agreed that this is one of the areas of most crucial need.

MORE DIRECT SERVICES TO CHILDREN AND CLIENTS

Be it resolved, That the Federal Government take appropriate measures for inclusion of the needs of the mentally retarded in the development of training programs of specialists in the speech and hearing areas. The increased recognition of the shortage of personnel relative to problems in the speech and hearing fields will hopefully result in measures at the national level to remedy an emergency situation. We earnestly request that full consideration be given to the mentally retarded in these areas.

FAMILY SERVICES

Be it resolved, That the maternal and child health grants of the Federal Government should not be limited to public health departments. In the development of programs for the mentally retarded by the various States, responsibilities have been assigned to agencies other than the public health department. It is therefore logical that the aforementioned grants should be made available more flexibly to the agencies designated by the States. The resolutions presented above reflect our thinking concerning those problems of an emergency nature which require Federal assistance. There were many other spheres of activity where vital needs were expressed and where lack of Federal support

had deterred progress. We earnestly request that the Federal Government begin to study the ways in which it can act as a catalyst to the development of day care services; for those retarded who require specialized care, not now generally available; specialized dental services for the retarded and training programs for dentists to provide these services; the amendment of the Hill-Burton Act to enable the construction of special medically and therapeutically oriented facilities for the defective delinquent, recreation programs as a supplement to day care activities, education, rehabilitation, residential care and as a common activity for those who can participate in no other organized program; for additional research activities; increased budget for wider distribution of health information aimed at reducing birth defects, improving prenatal care, pediatric care and child health supervision, and that additional funds be made available for increased field services of the Federal agencies concerned with the implementation of programs for the retarded. We need grants for schools in New England.

We feel that our findings are descriptive of the conditions which prevail in New England; that the recommendations herein stated will help assure that every mentally retarded child will have the opportunity to progress to his fullest potential.

We believe we have made known the problem and the needs. We pledge that if this Congress will implement these recommendations on the Federal level, the workers in the field of mental retardation in New England and throughout the country will transform millions of handicapped, dependent, rejected individuals into self-respecting, self-supporting dignified citizens of our Nation.

WORKSHOP PERSONNEL

Area: Mental retardation; cochairman: Miss Helen F. Freeman, Mrs. Rhoda Shaw Clark.

Eleanor Smith, regional office of vocational rehabilitation.

Manon B. Smith, director of education for mentally retarded children.

Bernice Chaletzky, special class teacher, Swampscott, Mass.

Mrs. Robin Hedges, executive secretary, Maine Committee on Problems of the Mentally Retarded.

Margaret Q. Doyle, public schools, Milton, Mass.

Alice M. Irwin, supervisor, special education, North Bedford, Mass.

Leonard Lyons, bureau of vocation rehabilitation.

Mildred Kronow, sheltered workshop, Bridgeport, Conn.

C. M. Green, State superintendent of schools, Union No. 21, Hampton, N.H.

Mrs. Ida E. Day, Everett public schools, special class teacher-educable.

Mrs. Helena Murphy, special class teacher, Bedford public schools.

Mary A. Decoster, recreational instructor for the mentally retarded, city of Boston.

John J. O'Donnell, principal of school.

Margaret L. Droney, supervisor, special education, Lowell public schools.

Mrs. Thomas Burke, teacher of trainable mentally retarded.

Joseph C. Lonergan, supervisor, division of special education, Massachusetts Department of Education.

Rhoda S. Clark, New Hampshire Committee on Special Education.

Mildred L. Brazier, representative, Walter E. Fernald State School, Waverly, Mass.

Burton Blatt, Southern Connecticut State College, 501 Crescent Street, New Haven, Conn.

George Brakner, Southern Connecticut State College.

Joseph Marra, Connecticut Bureau of Vocational Rehabilitation.

Clifford Beebe, bureau of vocational rehabilitation, Connecticut.

Helen F. Freeman, director, Caroll-Hall School of Lesley College, Massachusetts Commission on Mental Retardation.

Ann Switzer, Connecticut Association for Retarded Children.

Joseph Gerillo, State Bureau of Vocational Rehabilitation, Connecticut.

Charles P. Fonda, Mansfield State Training School and Hospital.

Ann Connors, social adjustment commission, caseworker, Connecticut.

Kathryn M. Haverstick, director, social adjustment commission, Connecticut.

Mrs. Frances R. Cook, counselor, social adjustment commission, Connecticut.

Joseph Freedman, Massachusetts Commission on Mental Retardation, Boston Association for Retarded Children.

Maurice Mezoﬀ, executive director, Massachusetts Association for Retarded Children.

Joseph Lavender, consultant, education for mentally handicapped children, Connecticut State Department of Education.

Stanley Meyers, executive director, Parents and Friends of Mentally Retarded Children.

Lawrence L. Rossi, supervisor, division of recreation, city of Boston.

Dr. Philip G. Cashman, director, division of special education, State department of education.

Pearl Vavrek, Connecticut Bureau of Vocational Rehabilitation.

Ira W. Gabrielson, community program for retarded children, Connecticut State Department of Public Health.

Dr. Frederick J. Gillis, assistant superintendent in charge of exceptional children, Boston public schools.

Paul V. Sherlock, State supervisor of education for handicapped children, Rhode Island.

Clifford C. Beebe, Connecticut Bureau of Vocational Rehabilitation.

Mr. ELLIOTT. Now, the group that studied the neuromuscular and orthopedic problems will please report.

STATEMENT OF GERTRUDE NORCROSS FOR WORKSHOP STUDY COMMISSION ON NEUROMUSCULAR AND ORTHOPEDIC HANDICAPS

Miss NORCROSS. I am Gertrude Norcross, from the Connecticut Society for Crippled Children and Adults.

Mr. ELLIOTT. Miss Norcross, are you going to speak good and loud?

Miss NORCROSS. Yes, I think so. I have never been known not to be heard. I have a lot of faults, but that is not one of them.

Our particular section, Mr. Elliott, had a very exciting 2 days. In fact, we were still going strong at 4 o'clock yesterday afternoon.

As a result of this we are asking that we be given the opportunity to make use of that 5 days grace that you have allowed the various workshop groups and file a complete report with you which is being prepared over the weekend.

Mr. ELLIOTT. Without objection, we will be happy to receive the report from the group on neuromuscular and orthopedic problems and when the report is received it will be made a part of the record at this point.

(The report referred to follows:)

WORKSHOP REPORT ON NEUROMUSCULAR AND ORTHOPEDIC HANDICAPS

This is an interim report of the committee. A full description of deliberations will be given to the legislative committee within 5 days.

We propose here to simply indicate the major areas that were considered by the committee and present this outline as a guide for the legislative committee.

GENERAL CONSIDERATIONS

I. Composition of the committee

Seven persons from State rehabilitation agencies were represented. State departments of education, physicians, administrators, private rehabilitation, and special education agencies made up the remainder of the committee.

II. General considerations

1. Recognition of handicapped persons as an important segment of our economic and social life. We are requesting in these recommendations that the same services as are presently provided for the nonhandicapped be considered as basis to whole concept of this committee and indeed to the moral health of the Nation.

2. The fields of special education and rehabilitation are in close approximation in the area of neuromuscular and orthopedic problems, but not necessarily in need of general consolidation at this time. Each realizes the same services from time to time but this cannot mean that administrative or service controls should merge.

3. A basic feeling of this committee regarding employment, education and social activity for the handicapped is that, wherein possible integration in these areas with nonhandicapped persons should take place.

4. In areas of rehabilitation and special education, including again the educational, employment, and social areas of life, a close look at present age limitations and reductions should take place. We feel that this applies to all the areas that we will later present and so make a general statement at this time.

5. The committee is presenting basic recommendations concerning expansion, strengthening or redirection of existing programs and facilities in addition to thoughts about new services.

We have divided our work into the three traditional subgroups of treatment (and service) education and research.

However, in view of the short time we have had to prepare this material we feel it would be unfair to present conclusions to you without further refinement. We will therefore provide the committee with copies of our deliberations in 5 days.

I will be happy at this time to answer any specific questions concerning the work of our group.

ATTENDANCE SHEET

Louise Wilkin, Gaylord Farm, Wallingford.

Ruth M. Olson, New Britain Memorial Hospital.

Robert P. Hogg, Goodwill Industries.

Ruth A. Murray, Portland School Department.

George D. Dorian, M.D., Bureau of Vocational Rehabilitation.

Peter P. Corato, Bureau of Vocational Rehabilitation, New Britain, Conn.

N. N. Marshman, United Cerebral Palsy Associations of Massachusetts.

S. J. Liao, M.D., Easter Seal Rehabilitation Center, Waterbury, Waterbury Hospital.

Elizabeth Comfield, M.D., State Welfare Department.

Dr. Denis S. O'Connor, New Hampshire Area Rehabilitation Center, New Hampshire Curative Workshop.

Dr. Robcliff V. Jones, Grace New Haven Community Hospital, Yale University School of Medicine, Department of Physical Medicine.

Olga Gallan, Bureau of Vocational Rehabilitation, State Department of Education, Bridgeport, Conn.

Beatrice K. Bronson, State Department of Education, Hartford, Conn.

Amy L. Philips, Newington Hospital for Crippled Children.

Francis H. Harding, Massachusetts Rehabilitation Commission.

Thelma F. Parker, New Haven Rehabilitation Center.

Gertrude Norcross, Connecticut Society for Crippled Children and Adults.

Franklyn Graff, Board of Education, Westport, Conn.

Gray H. Curtes, Vocational Rehabilitation Division.

Bruce Cole, Bureau of Vocational Rehabilitation, Connecticut.

Mildred Stanton, Connecticut Department of Education.

C. W. Goff, M.D., attending orthopedic surgeon, Newington Hospital for Crippled Children.

Thelma Parker (per E.C.), New Haven Area Rehabilitation Center.

Mrs. Dorothy Singer, Boston University School of Education Rehabilitation.

Philip Hallen, The Boston Dispensary.

Lorraine R. Loiacono, State Welfare Department.

John C. Allen, M.D., Hartford Hospital, Newington Hospital for Crippled Children, University of Connecticut, School of Physical Therapy.

Joseph E. Pauleat, Bridgeport Goodwill Industries.

John C. Horman, Jr., Goodwill Industries of America, Inc.

Thomas F. Hines, M.D., Yale-New Haven Medical Center.

B. E. Foss, Newington Hospital for Crippled Children.

James B. Clemens, Newington Hospital for Crippled Children.

Mrs. John Langdon, Rhode Island Society for Crippled Children Meeting Street School.

Sarah C. Johnson, State Department of Health.

Mr. ELLIOTT. Now, may I ask you, Miss Norcross, was your committee fairly unanimous in its recommendations?

Miss NORCROSS. Yes. We have a few points that I don't know whether you want me to take the time now or not to bring out which were just a little different than any of the points which have been discussed today.

Mr. ELLIOTT. Will those be incorporated in the report?

Miss NORCROSS. They will.

Mr. ELLIOTT. That will be fine.

Miss NORCROSS. If you would like to have a brief summary of what we are going to include in the report, I can give that to you now.

Mr. ELLIOTT. All right, you may proceed, Miss Norcross.

Miss NORCROSS. The first thing that we would like to have you people consider is the fact that the handicapped are really a normal part of society, that we have orthopedic and neurological problems with us, we have always had them with us, and probably the rest of our lifetime we will have them with us.

The sooner we plan for these people the better it will be. We would like to have you consider, however, that the group talking this morning have been discussing the special services necessary to special schools, and so forth.

We feel that except for the very seriously handicapped in the orthopedic and neuromuscular group that we would like to have facilities established so that these people can be integrated into the normal worklife as rapidly as possible so that they are not kept in special classes indefinitely and that when they do get older they will have an opportunity for employment.

We spent a great deal of time discussing the relationships in the field of special education and rehabilitation since they were both meeting together in this committee.

The group felt that there was a very close approximation in the area of neuromuscular and orthopedic problems, but not necessarily in need of general consolidation at this time.

We felt that two separate activities should be carried on and that it was not advisable to merge the programs on a Federal level.

When you receive our report, you will find our recommendations of need divided into three subgroups in order that we could get somewhere in this large field that would be understandable.

We have divided our report into treatment and service, education, and research.

You will find that our recommendations in those three areas will be so divided.

Thank you very much.

Mr. ELLIOTT. Thank you, Miss Norcross.

Now, our next witnesses will be the representatives from the group who studied the problems of the emotionally and mentally ill.

STATEMENT OF JULIAN S. MYERS, ASSOCIATE PROFESSOR AND
COORDINATOR OF REHABILITATION COUNSELING AND TRAIN-
ING AT BOSTON UNIVERSITY

Mr. ELLIOTT. What is your name, sir?

Mr. MYERS. I am Julian Myers, associate professor and coordinator of rehabilitation counseling and training at Boston University.

Mr. ELLIOTT. Mr. Myers, you will talk good and loud, will you not?

Mr. MYERS. Yes, sir; I will try.

What I have just given you, sir, is a copy of the deliberations of our section on the mentally ill and what I would like to do is perhaps skim over this without emphasizing all the points, but perhaps putting some emphasis on what might be the most important elements.

Perhaps I should say in summarizing that from the general tenor of what we have reported, our conclusion would seem to be that with our present state of knowledge we can do a lot more in rehabilitating the mentally ill and emotionally disturbed than we are now doing.

We think that this will require more facilities and more well qualified personnel, personnel with what we would consider to be a rehabilitation type philosophy.

We had to break our group down into two sections to get through within our period of time.

The first tend to focus more on problems of children and special education.

The other is on problems of adult and rehabilitation, but we feel they are closely allied.

As a working formula we used the general idea that emotional illness refers to individuals whose functioning is impaired because of emotional and mental factors, most often due to noxious interpersonal experiences, but which also may have biological and neurological sources.

It was felt by some members of the committee that a definition is not indicated in legislation any more than you would define diabetes in legislation.

In other words, it was felt that a person diagnosed by a competent medical authority as being mentally ill would be a person who is mentally ill.

I am not sure there was complete consensus on this one point, but I think on other points we had a fairly good consensus.

With relation to personnel it was pointed out that presently there are programs ranging from fair to excellent to train personnel in psychiatry, psychology, social work, and for some teachers in special education.

Our group felt that consideration should be given to Federal support of programs for the provision both of educators capable of training teachers and for the training of individuals to serve as child development personnel and teachers of special education, including, of course, teachers for emotionally disturbed children.

For this purpose we would hope that there would be support through the Department of Health, Education, and Welfare for research in setting up criteria for these personnel for workshops and

demonstrations aimed at the high school and college level designed to attract suitable individuals to such professions.

Provisions with appropriate safeguards of scholarships or stipends on the college or professional school levels to attract qualified trainees.

Research in curriculum for the training of professionals including both the academic aspects and the field training aspects.

Provisions of grants, either directly or through the State, to universities to provide instructors and to field training centers to provide necessary supervisors.

We find all too often the supervisors in the field work situation do not have the professional preparation and background needed to supplement the training aspects.

The section dealing with children also stressed the need for the development of a new professional group which would be designated child care personnel. This type of personnel now exists in a wide variety of situations, but there is no uniformity.

It was felt that in a variety of situations such as day-care centers, residential treatment centers, special schools and so on, there was a need for this type of person and that the quality of their professional skills would determine to a large extent whether the children were helped or not.

Therefore, it was proposed that support be given, first on a trial basis and then if warranted on a continuing basis, for some joint arrangements between universities and treatment centers to establish a 2-year master degree program in child development and child care.

The universities would provide the appropriate professional courses including areas of psychology and dynamics while treatment centers would provide the supervisory learning experience.

This program would call for stipends for the trainees and provision for salaries along with appropriate overhead.

Turning next to service provisions, it was the feeling of the group that in order to encourage the States to act in accordance with a wide comprehensive view of disability that Federal legislation clearly should state that emotionally disturbed and handicapped children are not excluded from, but are to be considered within and among the generally recognized categories of exceptional and handicapped children for all existing and contemplated special provisions and laws.

In other words, there is a feeling that sometimes the emotionally disturbed child and perhaps other categories tended to be left out of legislation.

We would like to see this legislation as all-embracing.

We have included a tentative draft of a type of State aid program which we think is necessary in meeting the needs of the preschool child with emotional difficulties. That is contained in the report, and I won't go into it.

The next point, I had better read this. Children in adolescence who are hospitalized in long-term and short-term institutions are often deprived of necessary education advantages as many communities either do not recognize their need or feel it is not in their province or they cannot afford this.

Therefore, it was proposed that grants be made available for partial reimbursement to States or to local communities or to institutions for the provision of educational services for school age children

in adolescence who are confined to those hospitals or to residential treatment centers under public or private auspices.

In other words, we feel that these children need educational services as well as therapeutic services and they are not getting very much of this nature.

The section recognizes the existence of a problem which is poorly dealt with at the present time, which is primarily a diagnostic problem related to children under the age of 6 who come to attention because of deviant behavior.

Single visits are not adequate to come up with a proper diagnosis and to come up with proper treatment specifications.

Experience with these children suggests that proper diagnosis requires that they be observed in a controlled group setting over an extended period of time.

Then the diagnosis would be based on interaction with children, adults, behavior and so on.

It also involves work with parents, psychotherapy medication, and so on.

In this process we would hope to avoid hospitalization as much as possible for fairly obvious reasons and it is felt that this sort of diagnostic service and treatment could best be supplied by a therapeutic diagnostic nursery school type of program.

This, in turn, would require specially trained nursery school teachers, psychiatric, psychological, and social caseworker and group work personnel.

This is a fairly expensive program, we recognize, and would require subsidization if it were to be put into effect on a fairly appreciable basis.

We see two possible resources for such programs, the maternal child health title under the Children's Bureau program and community health projects under the NIMH grants.

We hope this could be strengthened by specific allocation.

Turning to the utilization of pilot and demonstrations projects which are now sponsored by various agencies of the Department of Health, Education, and Welfare, we feel these are very valuable things and many of them are coming up with important findings and indications for future forms of treatment.

However, currently, when the Federal support for these projects is terminated the whole project is all too often terminated and we would like to see further support in two ways. To provide for continuation of these projects long enough to provide sufficient opportunities for local or State funds to be developed to maintain them.

This would be a matter perhaps of a couple of years.

Or to provide funds to make it possible for other States and communities to adopt and to adapt this new information, the techniques, and the program which are demonstrated as making significant contributions.

So it is felt that the legislature should give serious consideration to the possibility of providing additional funds in these areas.

Otherwise, we feel that some of the important findings will be wasted. To determine which project should get further support there might be a board of review set up which would pass on the merits of these projects.

On our committee I was aware of the limited number of professionals available in any community for the increasing and diverse needs being proposed.

We would suggest as far as possible that Federal legislation encourage the States to develop programs which join with others to use in common such scarce personnel as psychiatrists, psychologists, special education people, and rehabilitation personnel.

We would not like to see each agency compete and segregate its services.

Mr. ELLIOTT. Thank you very much, Mr. Myers. We have enjoyed your report.

I will ask you the question: Was it fairly unanimous?

Mr. MYERS. Yes, sir. We had a good deal of unanimity as you can see from the report. I have not completed the section on rehabilitation aspects.

It is contained in the report, however.

Mr. ELLIOTT. Thank you very much.

(The report referred to follows:)

WORKSHOP REPORT ON EMOTIONALLY DISTURBED AND MENTALLY ILL

I. DEFINITION

The section is of the opinion that there is no special need to define the above categories other than in an operational way, any more than a diabetic person may be defined as one diagnosed by competent medical authority as suffering from the disease called "diabetes". In the same way, persons may be defined as emotionally disturbed or mentally ill if they are so diagnosed by competent medical authority.

In passing, it may be stated that this refers to individuals whose functioning is impaired because of emotional and mental factors, most often due to noxious interpersonal experiences, but which also may have biological and neurological sources.

II. PROVISION OF PERSONNEL

(a) There are at present programs of varying degrees of adequacy for the training of personnel in the fields of psychiatry, psychology, and social work and for the teachers of some kinds of exceptional children.

This committee feels that consideration should be given to Federal support of programs for the provision both of educators capable of training teachers and for the training of individuals to serve as child development personnel and teachers of special education, including particularly teachers for emotionally disturbed children.

This would involve support through the Department of Health, Education, and Welfare for programs such as these:

1. Research in criteria for the selection of the best suited individuals for recruitment for such professions.

2. Workshops and demonstrations of materials, aimed at both the high school and the college levels, designed to attract such suitable individuals to such professions.

3. Provisions (with appropriate safeguards) of scholarships or stipends on both the college and professional school levels to attract such qualified trainees.

4. Research in curriculum for the most efficient training of such professionals, including both diversified courses in the universities and varieties of practicum-field training.

5. Provisions of grants (directly or through the States) to universities to provide such instructors and to field training centers to provide the necessary supervisors and supporting personnel in such areas.

(b) The section desires to stress the need for the development of a new professional group.

There has been an increasing need to place children, incapable of being helped solely by individual approaches, in an ever-increasing variety of group situations including day care centers; residential treatment centers; children's villages;

special schools; children's wards or children's units of State or of private mental hospitals; and State training schools and other institutions for delinquent children.

In such institutions, a major part of the care of such children and of the treatment which will help to determine the success or failure of such placement, is provided by personnel given various titles, but who may be grouped together under the overall designation of child care personnel.

These individuals come from a variety of backgrounds but are generally without any formal training. They are expected to perform like professionals and truly could represent a new and valuable profession if adequately trained.

It is proposed that support be given, first on a trial basis and then if warranted, on a continuing basis, for some joint arrangement between appropriate universities and residential treatment centers to establish a 2-year master's degree, postgraduate program in child development and child care. The universities would provide the appropriate professional courses in child development, normal and abnormal psychology, group dynamics, etc., while the residential treatment centers would provide appropriate supervised learning experience.

This would call for stipends for the trainees and provision for salaries of instructors in the universities and supervisors and supporting personnel in the field training center, along with appropriate overhead.

III. PROVISION OF SERVICES

A. In order to encourage the States to act in accordance with such a wide view, the section suggests that Federal legislation clearly state that emotionally disturbed and handicapped children are not excluded from but to be considered within and among the generally recognized categories of exceptional and handicapped children for all existing and contemplated special provisions and laws. Examples include the provision of home teaching and services of school social workers; special classes; services of special personnel and consultants, such as psychologists and psychiatrists; summer program; purchase of such necessary rehabilitative services as individual psychotherapy.

As a further example of the type of State aid programs which should be supported by some Federal reimbursement, the section appends and endorses the following proposed draft act for the Commonwealth of Massachusetts prepared by the Massachusetts chapter of the National Organization for Mentally Ill Children:

"INTERIM REPORT OF THE COMMITTEE ON LEGISLATION REGARDING SPECIAL EDUCATION FOR EMOTIONALLY DISTURBED AND MENTALLY ILL CHILDREN

"Legislation to extend special educational and other benefits, comparable to those now available to other handicapped children, should include the following:

"I. DIAGNOSIS

"In order to qualify for aid under the following sections, a child must be diagnosed, according to regulations prescribed by the departments of education and of mental health, as emotionally disturbed or mentally ill to such an extent that his needs for specialized training or teaching cannot be met in a school class for normal children.

"II. DAY CLASSES

"The school committee of any city, town, or regional school district having resident therein any child, diagnosed as emotionally disturbed or mentally ill according to section I, shall, upon request of the parents or guardian of such child, provide a day program for training and education of such child in one of the ways set forth in subsections A, B, and C hereof:

"A. The school committee of any city, town, or regional school district may establish special day classes for emotionally disturbed or mentally ill children, under regulations prescribed by the departments of education and of mental health.

"B. Any city, town, or regional school district may join with one or more other towns, cities, or regional school districts to establish special day classes for emotionally disturbed or mentally ill children, under the regulations prescribed by the departments of education and of mental health, the cost of conducting such classes to be apportioned by agreement among the towns, cities, and districts so joining.

"C. Any city, town, or regional school district may send such child to day classes for emotionally disturbed or mentally ill children conducted within a reasonable distance from the child's residence, by any agency approved by the departments of education and of mental health, and may pay reasonable and necessary amounts as tuition to such agency.

"D. Any city, town, or regional school district may provide, or pay the reasonable cost of, transportation to and from special day classes for emotionally disturbed or mentally ill children resident therein attending such classes.

"E. Any city, town, or regional school district providing for special education of its resident children under sections A, B, and C, or transportation under section D shall be entitled to reimbursement by the Commonwealth for one-half the cost of such special education and transportation.

"III. RESIDENTIAL SCHOOLS

"The department of education or the department of mental health may, upon the request of the parents or guardians, send an emotionally disturbed or mentally ill child, for whom residential care is required or recommended by a competent diagnostic authority, to a residential agency, within or without the Commonwealth, approved by the department of educational and mental health as qualified to provide an adequate remedial and educational program for such child. The reasonable and necessary expenses for care and training of such child at such agency including his necessary transportation expenses shall be paid by the Commonwealth, but the parents or guardians of such child who are able wholly or in part to provide for his support and care, may be required to reimburse the Commonwealth therefor to the extent of their ability.

"IV. Any agency providing special day classes or residential remedial and educational programs for emotionally disturbed or mentally ill children may pay to persons caring for, teaching, treating, or supervising such children, compensation in excess of established salary scales for teachers in public schools for normal children. Such compensation, if commensurate with the specialized training and experience of such persons, shall be considered a reasonable and necessary expense.

"B. Children and adolescents who are hospitalized in short- and long-term institutions are often deprived of necessary educational advantages as many communities either do not recognize their need or feel it is not in their province or that they cannot afford this.

"Therefore, the section proposes that grants be made available for partial reimbursement to States or to local communities, or directly to institutions involved for the provision of educational services for school-age children and adolescents confined to hospitals (including psychiatric among them) or to residential treatment centers, whether under public auspices or under private (but nonprofit) auspices.

"C. The section recognizes the existence of a problem which is poorly dealt with at the present time. There are an increasing number of children under 6 years of age who come to attention because they are deviant in behavior. When seen on a single visit basis, or even on several visits, on an individual basis, by appropriate and skilled professions, they may be variously diagnosed (depending upon who sees them) as psychotic, brain-injured, mentally retarded, or a combination of these."

Experience with these children suggests that proper diagnosis requires that they be observed in a controlled group setting over an extended period of time, such diagnosis being based partly upon their interaction with other children, as well as with adults.

It also suggests that proper treatment of these children requires the use of such a controlled group environment over long periods of time, as well as work with the parents, individual psychotherapy with the child, and possibly the use of medications as well.

As there are a number of reasons for avoiding total hospitalization of children under 6 years of age, the environment required for both diagnosis and treatment may best be supplied by the provision of a therapeutic-diagnostic nursery school program.

This requires the provision of specially trained nursery schoolteachers and psychiatric, psychologic, and social caseworkers and group work personnel. The resulting care is much more expensive than that in the average nursery school and subsidization is required.

There are at present two possible resources for such programs: the maternal-child health title under the Children's Bureau program and the community mental health projects under NIMH grants. These could be strengthened by specific allocation.

IV. MEANS OF BETTER UTILIZATION OF PILOT AND DEMONSTRATION PROJECTS

There is considerable concern about the need to provide means of further extending and implementing programs of special education and rehabilitation (including direct treatment services) which are developed as demonstration projects, pilot studies, and research programs. Under current practice, termination of the project itself. It seems that further support is needed in two ways:

First, to provide for continuation of these projects long enough to provide sufficient opportunity for local and/or State funds to be developed to maintain them which is usually several years beyond the demonstration aspect of the special program.

Second, to provide funds to make it possible for other States and communities to adopt and adapt new information, techniques, and programs already demonstrated as being able to make significant contributions in the fields of special education and rehabilitation.

It is felt that the legislature should give serious consideration to the possibility of providing additional funds to meet the needs in these two areas. Without such funds for implementation it would seem that a significant portion of currently expended funds for research and demonstration or pilot programs in essence are not being fruitfully utilized.

One possible means of accomplishing this might be the establishment of boards of review similar to the reviewing boards currently allocating funds on the research and demonstration level, to recommend allocation of these funds on an extended support basis.

V. JOINT USE OF PERSONNEL

The committee is aware of the listed number of professionals available in any community for the increasing and diverse needs being proposed. It suggests that as far as possible Federal legislation encourage the States to develop programs which join with others to use in common such scarce personnel as psychiatrists, psychologists, social workers, special education, and rehabilitation personnel.

Mentally ill (rehabilitation aspects)

Personnel.—It is the feeling of the section that many more mentally ill people can be rehabilitated than is currently the case. It is our opinion that this can best be done by the development of comprehensive mental health teams within the hospitals and by coordinating the efforts of these teams with existing vocational rehabilitation service. Therefore, it is recommended that the Federal Government set up mental health grants to be made available to the States, for the purpose of developing and supporting within mental hospitals—

1. Rehabilitation teams, including such professions as psychiatrists, psychologists, vocational rehabilitation counselors, social workers, nurses, physical therapists, and occupational therapists.

2. Corresponding rehabilitation services such as therapy, vocational counseling, vocational training, education, social services, and recreational services.

In order to stimulate and encourage the recruitment of qualified rehabilitation personnel, it is recommended that the training aspects of Public Law 565 be revised so that traineeships can be made available to undergraduate students in their junior and senior years, provided that these students are both highly qualified for rehabilitation work and highly motivated to enter the field. Such traineeships would be in addition to the graduate level traineeships and would require an extension of the 2-year limitations that currently exist. The undergraduate training, where applicable, should be structured to prepare the individual for graduate specializations, as for example in the rehabilitation counselor programs.

A pressing need exists for the establishment of new mental hospital facilities. In order to encourage the States to develop such new facilities, it is recom-

mended that the provisions of the Hill-Burton Act be modified to provide a more favorable formula to the States for the building of new facilities for the mentally ill and for the establishment of rehabilitation services in these facilities.

Gradual transition from hospital to the community is often a vital part of the rehabilitation process. The halfway house offers certain patients such a gradual transition. It is recommended that the States be encouraged to set up halfway houses to further the social and vocational rehabilitation of the institutionalized mentally handicapped population, through current or proposed Federal legislation.

Services.—It is recommended that the name of the President's Committee on the Employment of the Physically Handicapped be changed to the President's Committee on the Employment of the Handicapped so as to include those individuals with mental handicaps.

It is recommended that current rehabilitation legislation be modified so that the State vocational rehabilitation agencies will be given greater latitude in providing services to disabled individuals who may be able to achieve physical and social independence even though they may not necessarily be employable after such services have been provided.

In determining an applicant's eligibility for financial assistance under Public Law 565, the Division of Vocational Rehabilitation may exclude as "available resources" a moderate amount in liquid assets in order to provide a reasonable degree of economic stability and for a reserve for unexpected emergencies. We strongly believe that rehabilitation clients while in active status should have the same degree of economic stability and reserve for emergencies.

Therefore, we recommend that Public Law 565 be amended to permit vocational rehabilitation clients who as applicants are devoid of such assets, but who while in active status become earners to accumulate from their earnings liquid assets equal to the amount which the State rehabilitation plan would have permitted them to exclude as "available resources" while they were applicants.

General.—The policy of an open-end grant currently being used for public assistance funds has the advantage of encouraging the States to expand the program involved. Therefore, it is recommended that grants made to the States for vocational rehabilitation be made through open-end appropriations so that there will be an inducement to the States to enlarge their services.

We believe that the existing policy of the Office of Vocational Rehabilitation requiring matching funds on the part of agencies undertaking research and demonstration projects should be continued where there is an established basis for local financial support. However, we feel that many valuable projects, particularly in new areas, are excluded from consideration because matching funds are not available. Therefore, we recommend that the Office of Vocational Rehabilitation should be authorized to contract and pay for the entire cost of research projects, when this research is considered desirable but matching funds are not available.

While this section of the New England study group has been considering the needs of the mentally ill in the areas of special education and rehabilitation, we support the principle of coordination and integration of programs and services. In general, we feel that it is not desirable to meet the needs of special disability groups in isolation if such needs can be met in conjunction with services offered to other disability groups. We feel that fragmentation of services, proliferation of services, and the establishment of competing services should be avoided whenever possible. We favor the intelligent, constructive use of all community agencies such as clinics, schools, departments of education, family agencies, and child guidance clinics whenever they can contribute to comprehensive rehabilitation. We support the principle of integrating special education services with rehabilitation services so that the disabled individual will receive optimal support and assistance in the form of a comprehensive program that will enable him to take his place in the community as a self-respecting, self-sufficient citizen.

Mr. ELLIOTT. Our next group is that of the gifted.

Will the person designated to speak and present the report from that section of the workshop please come around.

STATEMENT OF PEARL ROSENSTEIN, ON BEHALF OF THE WORKSHOP STUDY COMMISSION ON THE GIFTED

Mrs. ROSENSTEIN. I am Dr. Pearl Rosenstein. I am associated with Southern Connecticut State College.

Mr. ELLIOTT. Now, Doctor, what was your name, again?

Mrs. ROSENSTEIN. Dr. Pearl Rosenstein, assistant professor, Connecticut State Teachers College, and principal of the Barnard Laboratory School, where we have done considerable research in the area of gifted.

We know that today the educational system throughout the United States faces many crucial issues and also criticisms.

One area in which we are greatly concerned is the area of losing so many of our very bright youngsters who enter high school and then fail to go on beyond high school education. Statistics have indicated that 50 percent of the top one-third of our young people who should go on into higher education are not, and that we are losing in this group many potential leaders not only in the sciences, but in government, religion, education; in the social service work, in economic and many other areas, and this is a pitiful waste of human resources in our own country.

Mr. ELLIOTT. Dr. Rosenstein, did your group consider the impact that the National Defense Education Act is making in that field?

Mrs. ROSENSTEIN. Yes. The basic report of the committee is recommendations for revision of certain areas of the National Defense Education Act. One of the things we are greatly concerned with is this comparative criticism of our own system of education with that of other systems throughout the world, especially the European and the Russian system of education.

Now, we differ in our philosophy of education. We know that here in the United States we attempt to educate more young people at a higher level of education than any other country in the world, that ours is a universal system of education as compared with the European system usually called the elite system of education.

If you were to visit Russia today in their schools their philosophies are one of cohesiveness where most people all work for the state, that the individual has very, very little bearing as an individual and only as he can contribute to the state.

This is their basic philosophy of education.

If you move over into England you will find that the English basic philosophy of education is one of character education, where if you educate the character you educate the mind.

Mr. ELLIOTT. Dr. Rosenstein, I agree generally with what you are saying about the Russian system of education, but I am impressed very much by the fact that Russia last year graduated about a half million people more from its high schools than we graduated from our 27,000 high schools.

Mrs. ROSENSTEIN. One of the reasons, of course, is population. Their numbers are greater.

Mr. ELLIOTT. But that half million might offset that difference in population just about and would indicate that they are steering sharply now from the selective education that most of the European countries have had all along over to a system of somewhat democratic education.

At least, I have that impression from the study that I have made of it.

Mrs. ROSENSTEIN. Yes.

Another thing I think we have to consider is that their type of graduates, for example, those youngsters who go into their technical schools, their middle class, are considered scientific material, wherein in our schools they would be mechanical engineers of some kind.

There is a terminology we have to be concerned with, too, as well as some of the facts and figures.

But our concern is with our own group of young people whom we are losing on the higher level of education. This is primarily due to three major reasons as we can see them in the field of education.

One is lack of motivation. There is something that these people lack in wanting to go on.

Second is the lack of preparation.

Third is the lack of financial means of doing it.

Now, the area of preparation and motivation I feel is primarily the concern of the administrators and educators in our schools. We need to revise our programs of education. We need to build new courses study and new curriculum.

We have to devise new means of motivating these youngsters so that they do develop love of learning.

All of this requires research of one nature or another, pure and practical research. This is our great concern.

Although there has been an upgrading on the secondary level, that is, there has been more financial means made available through the merit scholarship program, through private industry, through colleges and universities, we feel that waiting for these youngsters to get into the secondary school is too late.

The area for identification of these youngsters must be on the elementary level. This is one of the great needs, a revision of the programs and means of identifying youngsters on the elementary level as they enter elementary schools.

We know, those of us who are associated with schools, that study habits and basic skills are usually developed at age 7, 8, and 9. It is too late to wait to give them that type of training when they get into the intermediate grade or into junior high school.

So we must find ways and means of identifying these youngsters at a very early age. This is where we call upon the committee to help us and to assist us.

Now, this report is a compiled report, a unanimous report of a group representing many universities and colleges in New England, high schools, in New York and New England, institutions as well as private and public school systems.

We have had, I might add, one of the most interesting sessions I have ever attended in any college or university courses. I think that in this type of meeting that we attended our exchange of opinion was more valuable than any I have ever attended before. It was a privilege to be able to sit in and meet some of the people and exchange ideas with them.

However, I do not want to take too much of your time. These are the recommendations that this committee has made for the gifted:

First, we have today techniques for identification of the gifted.

Those are available. They are becoming available to secondary schools through title V of the National Defense Education Act.

However, this is in the secondary area only.

I try to point up the need on the elementary level.

Second, we would recommend modification in this law to allow financial assistance for testing upon admission to public schools for identifying the gifted at the time when much can be done for them.

Third, we have today techniques and we have teachers who are capable of providing adequate instruction for the gifted but these programs which have started are too far and few between.

What we do need is a greater introduction of new programing for gifted throughout the United States. Those of us in New England who have been doing research on the gifted have had hundreds of letters this past year many of which came from Hawaii and Panama Canal Zone, Alaska, Canada, New Zealand, and many other areas of the world, requesting the new curriculum guide which we have developed for our children, requesting their characteristics, their identification of high abstract reasoning that these youngsters have, their retention expanse, and we have forwarded this material, but we are limited in the amount.

The important thing is to recognize that there is an awakening and there is a request and there is seeking of information in how to deal with this very important problem.

Therefore, what we need is funds to assist in the conversion of existing school programs to allow for better instruction of the gifted.

Fourth, we have today programs such as the St. Paul School program for advanced studies in New Hampshire which provides for young people of high intellectual capacity in isolated areas who do not have the advantages of a large school system, and they meet during a summer institute where they are motivated and challenged and work with each other under able leadership.

This is the type of program we need to develop in many more rural communities throughout the United States.

Now, on the elementary level theret are some very good programs here in New England; Brockton, Malden, and New Haven have done considerable research. However, they are quite inefficient in that there is a lack of continuity and distribution of the essential material that comes out of these programings.

Therefore, we would recommend that provision of the national and regional centers to provide leadership and consulting services for the assistance of existing programs and stimulation of new ones.

Fifth, we have a very limited amount of research today completed and some in progress concerning the nature of gifted. We are organizing programs in helping teachers to better understand the gifted children, but what we do need is a great deal more research at the theoretical and practical levels to provide educators with a broad understanding of giftedness.

Now, in title V of the National Defense Act this provides for training and guidance, counseling and testing of gifted children.

However, there is a need for more specialists to be included in this act, and this would include school psychologists, administrators, and classroom teachers, in order to broaden the program to include people who are and can be trained to identify and guide the gifted.

Last, the increasing number of gifted children who will be identified and are being identified in early childhood and elementary school require, as they enter and pass through high school, a more broadened aid program for financial assistance.

It seems almost impossible now that private industry and private scholarships will be able to meet the need of these young people who will eventually reach the high level in the high school range.

Therefore, we recommend a scholarship program on a national basis to insure a full secondary school opportunity for the gifted.

(The report referred to follows:)

NEW ENGLAND REGIONAL WORKSHOP IN SPECIAL EDUCATION AND REHABILITATION—
(COCHAIRMAN: ROBERT M. KELLOGG AND R. PHILIP HUGNY)

Area: The gifted

What we have	How do we use it	What do we need
1. Tests and techniques for identification of giftedness are available.	These are becoming available to secondary schools through title 5 of the National Defense Education Act.	Modification in this law to allow financial assistance for testing upon admission to public schools, for identifying the gifted at the time when much can be done for them.
2. Techniques and teachers capable of providing adequate instruction for the gifted.	Local programs of instruction for a group of gifted students within a school system.	Funds to assist in the conversion of existing school programs to allow for better instruction of the gifted.
3. Programs such as the St. Paul's School advanced studies program in geographic areas where local programs are lacking.	Provision of educational opportunities for gifted high school students which are unavailable to them in their own schools.	Provision of scholarship funds to allow gifted secondary school students to take part in summer programs approved by the Office of Education.
4. A number of good but isolated programs of special education for the gifted in various sections of the country; i.e., Brockton, Malden, and New Haven.	With considerable inefficiency as liaison between them is negligible.	Provision of national and regional centers to provide leadership and consulting services for the assistance of existing programs and the stimulation for new ones.
5. A very limited amount of research completed and in progress concerning the nature of giftedness.	In organizing programs and in helping teachers to better understand the gifted children in their classes.	A great deal more research at the theoretical and practical levels to provide educators with a broad understanding of giftedness.
6. Title 5 of the National Defense Education Act provides training in guidance, counseling, and testing of gifted children.	To provide guidance training for a limited number of persons with particular qualifications.	A broadening of this program to include the following persons who are involved in identification and guidance of the gifted: 1. School psychologists. 2. Administrators. 3. Classroom teacher.
7. Increasing numbers of gifted children graduating from programs in the elementary and secondary schools.	To prepare these young people for superior performance at the post-secondary-school level.	A scholarship program on a national basis to insure post-secondary-school opportunities for the gifted students.

ATTENDANCE SHEET

Nicholas J. Wells, State department of education.

Irene Feltman, Southern Connecticut State College.

Clara M. Thurber, dean, Lesley College.

Edward Frankel, Bronxville High School of Science.

Frederick Jervis, director of counseling services.

R. Philip Hugny, St. Paul's School, advanced studies programs.

Pearl Rosenstein, Southern Connecticut State College and New Haven public schools.

Arlene J. Walton, director of testing, Malden public schools.

Abraham M. Zeichner, clinical psychologist, Connecticut State department of mental health.

Edward Gordon, director, office of teacher training.

Dorothy E. Sharples, art director, chairman of curriculum committee.

Derwood A. Newman, superintendent, Needham public schools.

Roberta M. Kellogg, associate professor, Brown University.

Mary Martin, assistant principal.

Bertha Carter, director of education for physically handicapped children.

Margaret Otto.

Dr. Gall.

Dr. Frampton.

Mr. Light, liaison person with the Association for the Gifted.

Mr. ELLIOTT. Thank you very much.

Our next group is that of the work with visually impaired.

STATEMENT OF FREDERICK GREEHAN, ON BEHALF OF WORKSHOP, STATE COMMISSION ON THE VISUALLY IMPAIRED

Mr. GREEHAN. Mr. Chairman, members of the subcommittee, my name is Frederick Greehan, in official capacity supervisor of the rehabilitation bureau in the Massachusetts Division of the Blind.

Our group as yet has not finalized its written report; it is in the process of preparation. We would request permission to file it in written form within the very near future.

Mr. ELLIOTT. Without objection the written report will be made a part of the record when it comes in.

Mr. ELLIOTT. Now was the report fairly unanimous, Mr. Greehan?

Mr. GREEHAN. Yes, Mr. Chairman, it was unanimous on over 20 proposals and specific recommendations that we have to make. On the one other proposal there was a substantial majority and on only one proposed suggestion did the group turn it down.

On behalf of the workshop I would like to express the thanks of our group for this opportunity to get together in a workshop of this type. We feel it was a wonderful opportunity because in our group we had 36 persons present representing all of the New England States and a few persons from outside of the New England area.

Now under the rehabilitation side of this situation we had several proposals, but due to the lateness of the hour I would like to mention only three that refer to material that has not been covered here today in one form or another.

An unmet need concerned the vending stand program of the blind. The proposed solution the group is making is that Public Law 732, as amended, the so-called Randolph-Shepherd Act, be further amended to preclude income from vending machine and public buildings accruing to any group other than the blind vending stand operator in that particular building.

With respect to the independent living type of legislation, the workshop wished to record itself as being in favor of this type of legislation and the theory behind it and the group commended the idea of extension of services to more clients, but expressed the strong hope that such an extension of services would not destroy or materially interfere with the present vocational rehabilitation program.

Another recommendation on the rehabilitation side is that the Federal Office of Vocational Rehabilitation sponsor on a regional basis

biennial meetings of State rehabilitation staffs along with OVR personnel to exchange information and discuss current and proposed techniques in the field, this to be done on a grant basis so that the idea that the State personnel have in obtaining permission to travel out of the State would be overcome.

And, a further recommendation that the Office of Vocational Rehabilitation sponsor college-operated courses in small business enterprise operations, including vending stands similar to the course now operated by placement counsel for the blind at Southern Illinois University.

Briefly, just a few of the recommendations made for special education of the visually impaired group. There was a great discussion of the teacher shortage situation in this area, as well as in other areas, as we have heard here today.

The shortage of qualified teachers is not confined to the education of handicapped children, but the feeling was that its effects were perhaps more serious in this area.

The group waited to recommend that in addition to a consultant recently appointed to the Office of Education for exceptional children, that a highly qualified staff be added to this particular section and include in the responsibilities of this staff a nationwide study of educational services offered blind children with particular reference to the problems of training teachers adequately to teach the blind and the duty of recommending desirable standards to State departments of special education.

Also, it was recommended that Public Law 85 be amended which deals with the expansion of teaching in the education of mentally retarded children through grants to institutions of higher learning and State educational agencies.

It was proposed that this law be expanded to provide similar services to teachers of blind children or as an alternative new legislation be submitted to accomplish the same end.

There were proposals concerning the shortage of nonteaching professional personnel which would include such persons as psychologists, social workers, educational counselors, speech therapists, and so forth.

It was recommended that the aforementioned consultant and proposed staff in the Office of Education make a study of this situation, as well.

With respect to the shortage of books and other educational material in public school classes it was felt that this was mainly due to the difficulty of supplying one or several copies of the text on short notice. The workshop recognized that legislation along this line is going to be submitted to Congress in 1960, but wished to go on record with this proposal, that the act to promote the education of the blind under which the American Printing House for the Blind at Louisville, Ky., supplies books and materials to the school, be amended to permit Federal funds to be used for the expenses of specialists or consultants to work both at Louisville and in the field on such technical problems as title selection, anticipation of needs, improved methods of production, problems of distribution, education and research and cooperate with volunteer transcribers.

The present authorization of \$400,000 annually should be increased to whatever sum is needed and the workshop draws particular attention to the needs of partially seeing children for more large type books. I believe that will conclude my brief summary.

Mr. ELLIOTT. Thank you very much, Mr. Greehan.

(The report referred to follows:)

REPORT OF WORKSHOP ON REHABILITATION OF THE VISUALLY IMPAIRED

Cochairmen: Mr. Frederick D. Greehan, Dr. Edward J. Waterhouse.

It is a great pleasure to make this report of the workshop on rehabilitation of the visually impaired to the Subcommittee on Special Education of the Committee on Education and Labor of the U.S. House of Representatives. There were 31 persons present at this workshop session, with at least 1 representative present from each of the 6 New England States, as well as 2 persons who came as observers.

The workshop group adopted proposed solutions to 15 unmet needs in the field of rehabilitation of the visually impaired. Of these 15 proposed solutions, the vote to adopt the proposed solutions was unanimous on 14 of them. The group voted down the proposed solution to one unmet need and this suggestion is filed as a minority report.

Of the 15 unmet needs with their proposed solutions, 4 of them dealt with changes in Public Law 565, 2 dealt with the Office of Vocational Rehabilitation, 1 dealt with mobility training, 1 dealt with the Hill-Burton Act, 1 dealt with vending stands for the blind, 4 dealt with title X on aid to the blind under the Social Security Act, 2 dealt with title II on social security benefit payments under the Social Security Act. The minority report dealt with Public Law 565.

The workshop group on unmet needs of visually impaired persons which met at Yale University wished at the outset to record itself as being in favor of rehabilitation in its broadest possible meaning. The group decided to adopt the following definition of rehabilitation:

"Rehabilitation is the process of restoring the handicapped individual to the fullest physical, mental, social, vocational, and economic usefulness."

The workshop group then dedicated itself to the task of pointing out what it considered the unmet needs in the field of rehabilitation of the visually impaired in the New England region. The workshop attempted to be as specific as possible without giving the costs involved in any of its proposals since they would be too difficult to determine within a reasonable degree of accuracy.

Unmet need No. 1. Change in Public Law 565 concerning small business enterprises program.—Several persons expressed dissatisfaction with the present provisions of Public Law 565 with respect to the inability of the State agencies to pay for items such as rent and utilities for more than a period of a month and for the renting of operational equipment for more than a period of 4 months. Rehabilitation personnel believe that these limitations are pennywise in that they may so hamstring the blind person who is being helped in a business project that they could possibly contribute largely to the failure of the business.

Proposed solution: Public Law 565 and its attendant regulations should be amended so that the State vocational rehabilitation agency may be authorized to pay necessary operational expenses for blind clients engaged in small business enterprise programs for a period not to exceed the first 12 months.

Unmet need No. 2. Change in Public Law 565 concerning small business enterprise program.—People from different States expressed dissatisfaction with the provisions of Public Law 565 which relate to the provision of maintenance following the placement of a client. Under the present law it is necessary to discontinue his maintenance either at the time he receives his first paycheck or at the end of 30 days, whichever occurs sooner. This has created an injustice for many blind clients who are being set up in a business enterprise and who may have had to move considerable distance from their home location in order to begin such a business.

Proposed solution: Public Law 565 and its attendant regulations concerning provision of maintenance should be amended to provide that "a reasonable period of time following placement" be interpreted to permit State vocational rehabilitation agencies to provide maintenance for clients for a period not to exceed the first 12 months following job placement, rather than the current maximum period of 30 days.

Unmet need No. 3. Strengthening of Division of Services to the Blind in the U.S. Office of Vocational Rehabilitation.—There is inadequate understanding on the part of rehabilitation personnel who do not specialize in services to the blind of the special problems which result from blindness and the techniques of helping to meet these problems.

The fact that blind persons comprise only a small portion of the handicapped persons served under Public Law 565 makes it impossible for administrative personnel responsible for the operation of the total Federal-State rehabilitation program to devote sufficient time to the special needs of blind persons to become adequately familiar with the best means of meeting their needs and helping them achieve their optimum potentialities. Thirty-seven States now have specialized rehabilitation agencies for the blind. The remaining States should be encouraged to establish specialized agencies as soon as practicable.

Proposed solution: The U.S. Office of Vocational Rehabilitation should strengthen its services to the blind, and assign one full-time consultant on services to the blind to each of its regional offices. In addition, the Division of Services to the Blind in the central office should be strengthened. At present the regional representatives of the Office of Vocational Rehabilitation are in no way responsible to the Chief of the Division of Services to the Blind. This relationship should be changed so that the Chief of the Division of Services to the Blind would have more than a consultative role in planning and policy determination regarding problems of the blind.

Unmet need No. 4. Shortage of mobility instructors and need for mobility training.—There was considerable discussion about the importance of mobility training for blind persons as a necessary part of any vocational or total rehabilitation process. The group recognized the fact that work is now going on which hopefully will result in the creation of training programs which will provide more qualified mobility instructors for use in the various States.

Proposed solution: The group wished to record itself as being unanimously in favor of all such action which will promote the increased ability of blind persons to obtain mobility instruction from qualified teachers.

Unmet need No. 5. Lack of facilities to provide necessary rehabilitation services for blind persons.—The Hill-Burton Hospital Construction Act of 1954 has been a wonderful help in establishing certain rehabilitation facilities. Experience under this act has revealed that most centers established are medically oriented to a large degree. The group felt that this was fine as far as it went, but that it did not go far enough.

Proposed solution: Broadening the Hill-Burton Act to provide equipment and facilities, other than those operated under medical sponsorship, necessary to rehabilitation or special education programs for the blind, such as diagnostic and treatment centers for blind children and youth, rehabilitation centers for blind adults and special workshops for blind persons.

Unmet need No. 6. The need to improve the Randolph-Sheppard Act (Public Law 732 as amended).—The Randolph-Sheppard Act was originally set up as a means of providing one of the most meaningful opportunities for the employment of blind persons, and over the years has accomplished a great deal toward this end. However, during this time there has been increasing evidence of the encroachment of vending machines in buildings where the vending stand was or could be made adequate to provide for the occupants of the building. It is felt that pressures have been brought to bear on the officials in charge of the building, resulting in making it difficult for blind persons to have the opportunities which Congress intended. There is no desire, however, on the part of those working with the blind nor on the part of blind vending stand operators to insist on stands being set up where a cafeteria is clearly indicated, but many blind persons can and do successfully operate snack bars which market a much larger variety of goods and foods than that originally contemplated in the Randolph-Sheppard Act. The device of utilizing vending machines has in some instances been employed in order to divert income to purposes other than those authorized in the act.

Proposed solution: Public Law 732 should be amended (a) to preclude the income from vending machines accruing to any group or purpose other than to the blind operators. Further, the installation of such vending machines should be limited to areas which are not feasible for vending stands; (b) to expand the definition of a vending stand in order to encompass snack bars and similar merchandising operations; and (c) so that provision be made within the appropriate Federal agency for appeals from departmental decisions contradictory to the purposes and intent of the law.

Unmet need No. 7. Condition of unemployable blind persons.—Since the social and economic handicap of blindness is very frequently increased by factors of advanced age, poor health, secondary disabilities, and work background and aptitudes which cannot effectively be used without sight, many blind persons are unemployable, and about two-thirds of these unemployable blind persons find that living with public assistance cannot be avoided. In view of this, the subsistence provided by public assistance is inadequate to support wholesome morale in these blind recipients and, consequently, results in unhappiness for the recipients and deterioration of the social setting in which they live.

Under the present law, welfare agencies, as well as friends and relatives who have no legal responsibility for these blind persons but who may be interested in ameliorating their condition are prevented from offering any regular financial assistance by the fact that any such assistance is nullified by an offsetting reduction in the public assistance grant.

Not only is there need for additional supplementation without the application of current offsetting provisions; but many blind persons could be given an important sense of belonging, and of being useful, if they were encouraged to undertake part-time remunerative employment.

Proposed solution: Title X of the Social Security Act should be amended to mandate the exclusion of an aggregate \$1,200 net income per year from any source—not restricted to earned income—in computing the resources of blind recipients of public assistance.

Unmet need No. 8. Condition of blind persons who possess a limited or full potential for employment.—Blind recipients of public assistance who are capable of partial or full self-support are denied an adequate incentive to help themselves, as no portion of their earnings, beyond the meager limit of \$50 per month, can be used to improve their severely depressed standard of living under the present law. They are denied the values accrued from work, as the satisfaction that work can afford lies largely in the tangible rewards of work. This condition tends to perpetuate the frustration of being unable to rise above a subsistence level of living. It produces a defeatism and loss of dignity for the blind persons involved, which diminishes their abilities to contribute to the economic and social health of the communities in which they live.

Those blind persons who have been self-supporting prior to having to resort to public assistance and who have some potential for regaining self-support find that the rewards of their thrift and hard work are nullified by the requirement that they exhaust or assign virtually all of their real estate holdings and their life insurance. This requirement tends to delay the acceptance of public assistance by impoverished blind persons, who undermine their own health and cause the deterioration of the social climate of the communities in which they live by their reluctance to accept public assistance under these circumstances. Along with the prohibition against saving by recipients of public assistance, it also imposes insurmountable barriers to the reestablishment of self-support.

Proposed solution: Title X of the Social Security Act should be amended to mandate that:

(a) The first \$1,200 per year of income from whatever sources be exempted in determining available resources plus one-half of all earned income in excess of \$1,200 until complete self-support has been attained;

(b) The cash surrender value of policy or policies of life insurance shall be disregarded in computing resources up to a cash surrender value of \$5,000, face value, of life insurance;

(c) The value of property used as a home shall be disregarded;

(d) Any additional resources in the form of real and/or personal property or income which are necessary to implement an approved plan for achieving self-support may be retained;

(e) For the purpose of encouraging and enabling a greater number of recipients of aid to the blind to become self-supporting, all expenditures incurred by a recipient in effecting his plan to become self-supporting, including payments made for the purchase of fixtures and material needed by him in effecting such plan, shall be deducted from gross income in computing net income, provided that such payments shall not be more than \$100 per month.

Unmet need No. 9. Inadequate appreciation of the needs and potentialities of blind recipients of public assistance.—Administrators of public assistance who are unable to devote an adequate portion of their time for studying the special needs and potentialities of blind persons fail to appreciate the difference between the unique conditions which affect blind recipients and those which prevail for

recipients of public assistance who are not blind and which form the basis upon which public assistance programs are developed and administered. This situation has resulted, generally, in the evaluation, on both the Federal and State levels, of public assistance administered to the blind by standard criteria applicable to other large categories and, inevitably, such an evaluation has failed to reveal the true condition of blind recipients of public assistance or to suggest the measures that are so desperately needed to alleviate their condition.

If this situation is to be remedied, there must be a differentiation of public assistance for the blind from other categories for the following purposes:

1. It is the only effective way of not having aid to the blind hopelessly scrambled with other programs which, through the sheer weight of numbers and controversy, pretty completely snuff out the different objectives needed in aid to the blind.

2. It places above ease of administration the needs of blind persons as the more important objective.

3. It provides for an administration which continuously recognizes and makes provision for the special needs and requirements of aid to the blind recipients.

4. It promotes a greater understanding on the part of those actually administering aid to the blind of the many problems peculiar to blindness, thus assuring a more effective and efficient administration.

5. It alone makes possible the full utilization of present available resources and the development of new resources which contribute to the attainment of self-care or self-support by blind recipients, thus providing a more economical administration.

6. It makes possible the formulation of separate rules and regulations which relate directly to the needs of blind persons, thus providing a framework of administration which is geared to the problems incident to blindness and to the objectives to be sought.

7. It provides direct and constant access to top management with respect to the needs of the program.

Proposed solution:

- (a) That each State agency administering or supervising the administration of aid to the blind should create a bureau or division for the blind devoted to carrying out the administration or supervision of administration of aid to the blind. This is, in our view, the only truly effective means of assuring a reasonably adequate solution to the problem as stated;

- (b) That title X of the Social Security Act should be amended to provide at least one full-time consultant on services to the blind in the public assistance office of the U.S. Department of Health, Education, and Welfare;

- (c) That the Bureau of Public Assistance should regularly collect and publish detailed statistics on recipients of aid to the blind.

Unmet need No. 10. Need for increased Federal participation in public assistance for the blind.—The increased costs that will be entailed in improving public assistance for the blind cannot be absorbed by the States. Approximately 40 percent of the recipients of aid to the aged also receive benefits under title II of the Social Security Act, while only about 12 percent of the recipients of aid to the blind receive benefits under title II. With respect to aid to the blind, the current \$65 per month ceiling on Federal participation unduly depresses the standard of living of blind recipients. The long-range economic saving as well as the gains in human and social values can be achieved only by substantially increasing the ceiling on Federal participation.

Proposed solution: Title X of the Social Security Act should be amended to provide a revised formula which will increase the ceiling on Federal financial participation from \$65 per month to \$100 per month based, as now, on the average paid to all recipients within the category in the form of money payments and medical services.

Unmet need No. 11. Economic disadvantage of employed blind persons.—The necessity of selecting a place of residence convenient to public transportation, the necessity of patronizing those stores which provide maximum assistance in purchasing, the necessity of employing painting and other property maintenance services, the necessity for blind persons in the professions to secure reader services and a great many other conditions serve to impose an extraordinary burden of major consequence upon the financial resources of blind persons. This means that any blind person requires a significantly greater financial resource than his seeing peer to maintain a given standard of living. In addition, with very few

exceptions, a blind person's earning power is substantially lower than it would be if he could see or than it was before he became blind. Aside, therefore, from the relatively few fortunate blind persons who are able to earn a substantial income, any blind person in our society suffers a major economic disadvantage which tends to deny a basic sense of security. For these reasons and because the disability provisions of the old-age and survivors' insurance section of the Social Security Act have related benefits to compulsory acceptance of rehabilitation, to substantial gainful employment, to arbitrary age 50, and to a minimum definition of blindness, amendments are needed to resolve this sense of insecurity, to clarify the eligibility requirements under the act, and to make it truly a program of social insurance protection against disability.

Proposed solution: Title II of the Social Security Act should be amended to provide:

(a) Benefits as an absolute right regardless of age, income, or employment status, related exclusively to the establishment of the disability of blindness within the following definition: "Central visual acuity of 20/200 or less in the better eye with correcting lenses, or visual acuity greater than 20/200 if accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than twenty degrees."

(b) That the minimum requirement of coverage of 20 quarters of the last 40 quarters be reduced to no more than 6 quarters of coverage;

(c) That the present provision of compulsory acceptance of rehabilitation be abandoned, but that instead the Bureau of old-age and survivors' insurance be encouraged to suggest rehabilitation to all beneficiaries.

Unmet need No. 12. Blind persons who earned coverage after onset of blindness.—As a matter of equity, blind persons who have been employed in covered industry during the course of their blindness should certainly have available to them those earned benefits which are provided for all others suffering from the identical disability. The number of such persons will be relatively small since blindness occurs in the vast majority of cases around or after the normal age of retirement, and also because probably not more than 5 percent of blind persons are in covered industry. Such a provision would assure the blind person and his family a degree of basic financial security, and would effect a corresponding reduction in the expenditure of public assistance funds.

Proposed solution: Title II of the Social Security Act should be amended to make disability insurance benefits available to persons who have earned coverage since the onset of the disability of blindness.

Unmet need No. 13. Need for amendment of Public Law 565 to include so-called independent living provisions.—There was considerable and lengthy discussion with respect to independent living legislation. By this type of bill the group meant expansion of Public Law 565 to—

1. Make eligible for rehabilitation services severely handicapped individuals for whom vocational rehabilitation services may not be feasible but who, as a result of rehabilitation services, can achieve such ability of independent living as to dispense with the need for expensive institutional care or the need of an attendant at home.

2. Enable the Federal Government to assist in the establishment of nonprofit workshops and rehabilitation facilities.

3. Provide Federal assistance to the States to enable them to operate comprehensive evaluation programs for individuals who may benefit from rehabilitation services.

Proposed solution: The group wished to record itself as being in favor of the independent living type of legislation and the philosophy behind it. The group commended the idea of extension of services to more clients but expressed the strong hope that such an extension of services will not destroy nor materially interfere with the present vocational rehabilitation programs.

(This was the only proposed solution that did not receive a unanimous vote. Motion carried with considerable majority.)

Unmet need No. 14. Revision of Public Law 565 concerning the provision of reader service to blind persons in training.—The group expressed itself as dissatisfied with the provisions of Public Law 565 which placed reader service under a determination of economic need. Under its predecessor, Public Law 113, provision of reader service was interpreted as a training service and not subject to economic need.

Proposed solution: Public Law 565 and its attendant regulations should be amended so that the provision of reader service to blind clients in training would not come under a determination of financial need.

Unmet need No. 15. Better exchange of information among vocational rehabilitation personnel.—The group felt that vocational rehabilitation as a whole would benefit a great deal from regular meetings on a regional basis of Federal and State rehabilitation staffs to exchange information and ideas with respect to the program. Likewise, courses should be conducted for specialized State persons, such as vending stand operators and small business enterprise program counselors—somewhat similar to the current program conducted at Southern Illinois University for placement counselors of the blind.

Proposed solution:

(a) Recommend that the Office of Vocational Rehabilitation sponsor biennial meetings on a regional basis of State blind agency vocational rehabilitation supervisors, placement counselors, vending stand and business enterprise counselors in conjunction with the regional staff of the Office of Vocational Rehabilitation, as well as the necessary specialists in the Division of Services of the Blind and other sections in the Washington office of the Office of Vocational Rehabilitation. Such meetings should be sponsored by the Office of Vocational Rehabilitation on a grant basis or on a contract basis to allow all such State personnel to attend and to overcome the very real difficulty that States have in obtaining approval for out of State travel on limited travel budgets.

(b) Recommend that the Office of Vocational Rehabilitation take necessary steps to establish suitable courses for vending stand and business enterprise counselors of the blind.

MINORITY REPORT

By Dean P. Morrison

It is proposed that Public Law 565 should be amended to permit State rehabilitation agencies providing services for the blind to purchase any or all services on a per case basis from other agencies which operate programs or qualified individuals, that meet standards established by the State agencies.

The above was voted upon by the group—but was defeated.

ATTENDANCE SHEET

Baker, Frank, president, Maine Council of the Blind.

Beckley, Ralph W., assistant regional representative, office of vocational rehabilitation.

Bilodeau, Kenneth L., Massachusetts Department of Mental Health.

Carter, Mrs. Bertha, director of education of physically handicapped children, State department of education.

Cole, Virginia, director, division of the blind.

Cummings, Serena M., supervisor of blind and partially seeing children, Massachusetts Department of Education, Division of Special Education.

DeMartino, Matthew, rehabilitation supervisor, State Board of Education for the Blind, Hartford, Conn.

Driscoll, Regina I., supervisor, conservation eyesight classes, Boston Public Schools.

Greehan, Frederick D., supervisors of rehabilitation, division of the blind.

Heisler, William T., director, teacher training, Perkins School for the Blind.

Istas, Henry, legal counsel.

Johns, Frank Jr., director, Connecticut Institute for the Blind.

Johnson, Eleanor, administrator, 24 Exchange Place, Providence, R.I., Rhode Island Bureau for the Blind.

Landi, Elena, president, Rhode Island Federation of the Blind.

Marchisio, Guy J., chief of children's services, State Board of Education for the Blind, Hartford, Conn.

McCollam, H. Kenneth, executive secretary, State Board of Education for the Blind, Hartford, Conn.

McLaughlin, Mary E., supervisor of children's services, Massachusetts Division of the Blind.

Morrison, Dean P., director, division of services for the blind.

Nichols, Alaric, president, Vermont Council of the Blind.

O'Shea, Anita M., president, Associated Blind of Massachusetts.

Perry, Milton.

Rourke, Paul, supervisor, division of services for the blind.

Runci, Joseph M., Catholic Guild for the Blind.

Sullivan, James V., director, St. Paul's Rehabilitation Center for the Blind.

Taylor, John, National Federation of the Blind.

Trelease, George, rehabilitation counselor, Massachusetts Division of the Blind.

Van Vliet, Franklin, president, New Hampshire Federation of the Blind.

Virgulto, Jane, Connecticut Federation of the Blind.

Virgulto, Stanley, Connecticut Federation of the Blind.

Worden, Helen W., director, Rhode Island Association for the Blind.

REPORT OF WORKSHOP ON SPECIAL EDUCATION OF THE BLIND

Cochairmen: Mr. Frederick D. Greehan, Dr. Edward J. Waterhouse.

INTRODUCTION

Since there is no workshop dealing with partially seeing children, it was agreed that this workshop should have these children in mind in their deliberations. It was understood in these discussions that no distinction was being made between children educated under various systems, e.g., the residential school and public school programs for the blind, et cetera. They all need the best services obtainable.

The workshop made no attempt to analyze all the problems which face educators of blind youth, but endeavored to concentrate on areas where Federal assistance might most appropriately be sought. It recognized that in the United States the prime responsibility for solving problems resides in each State. Specifically, the workshop refrained from making proposals whose sole aim was the transfer of costs from the States to the Federal Government.

The Congress of the United States has, however, accepted responsibility in certain areas of the education of the blind and other handicapped groups. The workshop confined itself mainly to considering proposals for the expansion or improvement of services in these areas.

In the expectation that such a course would make easier the task of the congressional subcommittee, the workshop is issuing its report in a form suggested by the Workshop on Special Education of the Blind held in New York City in October 1959.

The workshop noted with satisfaction the cooperation and support currently being given by the Department of Health, Education, and Welfare to the American Foundation for the Blind and the American Association of Instructors for the Blind in programs for training mobility instructors and teachers of industrial arts. It noted also the greatly increased services of the American Printing House, made possible in the last few years by increased Federal appropriations, and amended legislation. Finally, it noted the recent change in legislation permitting the Library of Congress to include children's books in its services to blind readers.

PROBLEM I—TEACHER SHORTAGE

The shortage of qualified teachers is not confined to the education of handicapped children, but its effects are perhaps more serious in this area than in general. Facilities for training teachers of blind children are inadequate in most regions and entirely lacking in some. However, the shortage of candidates for some of the existing training facilities suggests that the problem is a complex one and that the addition of new facilities alone will not solve it. In many localities, teachers with no special training are made responsible for educating blind youth. Perhaps the need for establishing acceptable teacher and teaching qualifications for specific jobs is just as great as the need for facilities. With these thoughts in mind, the workshop submits the following proposals.

Proposal 1A

In addition to the consultant recently appointed, a highly qualified staff on the education of blind children (including partially seeing children) should be added to the Department of Health, Education, and Welfare in the Office of Education, Section for Exceptional Children and Youth. Included in the responsibilities of this staff would be a nationwide study of educational services offered blind children with particular reference to the problems of training teachers adequately to teach the blind, and the duty of recommending desirable teaching standards to State departments of special education and other agencies interested in and/or responsible for the education of blind children.

Proposal 1B

Public Law 85-926 deals with the "expansion of teaching in the education of mentally retarded children through grants to institutions of higher learning and to State educational agencies." It is proposed that this law be expanded to provide similar services for teachers of blind children, or as an alternative, new legislation be submitted to accomplish the same end. It is suggested that stipends for such purposes include readers' fees for blind fellowship recipients when the fellow requires such services. Such awards may be given at approved training centers or possibly through travel or through intensive workshops as well as study at colleges and universities.

PROBLEM II—SHORTAGE OF NONTEACHING PROFESSIONAL PERSONNEL

This group includes such skilled workers as psychologists, social workers, educational counselors, speech therapists, and others who work on a professional level with blind children.

The workshop recognized the importance of the services such persons can render to blind children and to their families. It recognized that a shortage exists of trained personnel with a special understanding of the problems caused by blindness in childhood and in youth.

The workshop felt that Federal aid in establishing special training facilities would be helpful, but recognized that this would only be a partial solution to the problem. In some regions throughout the country the services of these professional people are made available in ample measure, whereas in other regions, administrators of programs for blind children seem to be disinterested in providing these valuable services to blind children in their care. Other administrators, while interested, seem to lack the financial resources to employ these workers.

The vast range in variety and quality of services being offered from State to State and from locality to locality is a matter of considerable concern to the workshop, but they did not feel the reasons for this were entirely clear.

Proposal 2A

It was recommended that the staff suggested in proposal 1A investigate the reasons why the services of nonteaching professional personnel are not more widely employed on behalf of blind children and their parents. If their report indicates the desirability of such action, legislation should be prepared to provide grants in aid to the States for the setting up or expansion of such services. As in proposal 1B, awards may be given at approved training centers or possibly through travel or through intensive workshops as well as study at colleges and universities.

Proposal 2B

It was recommended that the Department of Health, Education, and Welfare be authorized to participate with public and private national and local agencies in setting up national and regional workshops and/or training seminars to encourage the increased use of these nonteaching professional services.

PROBLEM III—SHORTAGE OF BOOKS AND OTHER EDUCATIONAL MATERIAL

The workshop recognized that the existing shortage of books in public school classes is mainly due to the difficulty of supplying one or several copies of the text at short notice. It noted that in the residential schools where textbooks can usually be chosen in advance from available braille or large-type titles, a less serious problem exists than in the regular schools. The workshop recognized that considerable study of this problem has already taken place and is continuing. It recognized the value of the new plastic-forming reproduction technique perfected by the American Printing House which permits copies of hand-transcribed material to be reproduced expeditiously. It recognized also the great contribution being made by many volunteer groups of transcribers and readers. It noted in particular the tendency among these groups to pool their problems and cooperate with each other.

The workshop does not believe that an adequate supply of braille or recorded materials can be supplied to the pupils in their regular schools without the continued support—perhaps even on a greater scale than at present—by these volunteers. Historically, even the best-equipped residential schools have depended in some measure on volunteer transcribers and readers.

The workshop recognized that legislation which will be submitted to Congress in 1960 will permit the American Printing House to meet more effectively some of the urgent needs of blind children. It is hoped that this legislation will meet with the approval of the House Committee on Education and Labor and of the Congress as a whole. Nevertheless, in case this approval is not obtained, proposal 3A, which follows, is submitted. Proposal 3B and 3C are not in any way associated with this pending legislation.

Proposal 3A

The Act to Promote the Education of the Blind, under which the American Printing House for the Blind of Louisville, Ky., supplies books and material to the schools, be amended to permit Federal funds to be used for the expenses of specialists or consultants to work both at Louisville and in the field on such technical problems as title selection, anticipation of needs, improved methods of production, problems of distribution, educational research, and cooperation with volunteer transcribers. The present authorization of \$400,000 annually should be increased to whatever sum is needed. The workshop draws particular attention to needs of partially seeing children for more large-type books.

Proposal 3B

That the American Printing House be granted funds to supply braille paper gratis and braille writers on loan to volunteer transcribers duly certificated by the Library of Congress. Transcribers accepting such services would be required to sign an agreement to braille an agreed minimum amount of material annually, and to return the braille writer to the American Printing House for the Blind when no longer used.

Proposal 3C

If necessary, the Library of Congress should be authorized to expand its program of training transcribers and certifying proofreaders. The workshop is not in favor of reimbursing the services of hand transcribers, proofreaders, or recorders from Federal funds. (This does not apply to the current program of the Library of Congress.)

PROBLEM IV—STUDY-DEVELOPMENT OF THE BLIND CHILD

PROBLEM V—STUDY PROBLEMS OF THE BLIND CHILD WITH ADDITIONAL HANDICAPS

The workshop found itself in substantial agreement with the points of view of the New York Workshop on these two problems and endorsed the recommendations contained therein.

PROBLEM VI—FEDERAL AID FOR EDUCATION OF BLIND CHILDREN

The workshop recognizes that the additional cost of special education is considerable and would urge a further study of this matter by the Department of Health, Education, and Welfare. Proposals for Federal aid in certain areas are included under specific problem headings.

PROBLEM VII—USE OF AVAILABLE FEDERAL FUNDS

There is evidence that available funds for grants and aids for research have not been applied effectively to the educational problems of blind children.

Proposal 7A

The Department of Health, Education, and Welfare is requested to study this matter with a view to a more effective use of its resources.

PROBLEM VIII—FINANCIAL RELIEF FOR PARENTS OF BLIND CHILDREN

Proposal 8A

The workshop concurs with the proposal made in New York amending the Internal Revenue Code to allow an additional exemption for dependent blind persons.

CONCLUSION

The workshop would like to place on record its appreciation of the interest of the Subcommittee on Special Education of the House Committee on Education and Labor in the problems of the education and rehabilitation of blind children.

ATTENDANCE SHEET

Ave-Lillemont, F. W., State Board of Education for the Blind.
 Baker, Frank, president, Maine Council of the Blind.
 Beckley, Ralph W., assistant regional representative, Office of Vocational Rehabilitation.
 Bilodeau, Kenneth L., Massachusetts Department of Mental Health.
 Carter, Mrs. Bertha W., Director of Education of Physically Handicapped Children, Maine Department of Education.
 Cole, Virginia, director, Vermont Division of the Blind.
 Cummings, Serena M., supervisor of blind and partially seeing children, Massachusetts Department of Education, Division of Special Education.
 Driscoll, Regina I., supervisor, conservation eyesight classes, Boston Public Schools.
 Fitzgerald, Dr. H. Kenneth, American Foundation for the Blind.
 Grant, J. E., Jr., Bureau of Vocational Rehabilitation, Connecticut Department of Education.
 Greehan, Frederick D., Jr., supervisor of rehabilitation, Massachusetts Division of the Blind.
 Heisler, William T., director, teacher training, Perkins School for the Blind.
 Johns, Frank, Jr., director, Connecticut Institute for the Blind.
 Johnson, Eleanor M., administrator, Rhode Island Bureau for the Blind.
 Landi, Elena, president, Rhode Island Federation of the Blind.
 Marchisio, Guy J., chief of children's services, State Board of Education for the Blind.
 McLaughlin, Mary E., supervisor of children's services, Massachusetts Division of the Blind.
 Morrison, Dean P., director, Division of Services for the Blind.
 Nichols, Alaric, president, Vermont Council of the Blind.
 O'Shea, Anita, president, Associated Blind of Massachusetts.
 Perry, Milton.
 Rosati, Etore, supervisor of education of the blind, Rhode Island Department of Education.
 Rourke, Paul, supervisor of vocational rehabilitation, Division of Services for the Blind.
 Runci, Joseph M., Catholic Guild for the Blind.
 Sherlock, Paul V., supervisor of the handicapped, Rhode Island Department of Education.
 Sullivan, James V., director, St. Paul's Rehabilitation Center for the Blind.
 Taylor, John, National Federation of the Blind.
 Trelease, George T., rehabilitation counselor, Massachusetts Division of the Blind.
 Van Vliet, Franklin, president, New Hampshire Federation of the Blind.
 Virgulto, Jane, Connecticut Federation of the Blind.
 Virgulto, Stanley, Connecticut Federation of the Blind.
 Waterhouse, Edward J., director, Perkins School for the Blind.
 Worden, Helen W., director, Rhode Island Association for the Blind.

Mr. ELLIOTT. Next, we will hear from the workshop group on the special medical problems.

STATEMENT OF MRS. KATHRINE HOWE, ON BEHALF OF WORKSHOP COMMISSION ON SPECIAL MEDICAL PROBLEMS

Mrs. HOWE. Mr. Chairman, my name is Kathrine Howe. I am in this field, you might say, a nonprofessional, being president of the board of directors of the New Haven area rehabilitation center.

Mr. ELLIOTT. Mrs. Howe, will you speak just a little louder, please?

Mrs. HOWE. Yes, sir. Our workshop group consisted of 36, this being the total number in attendance. I might say there were comings and goings. At no time probably were there 36 present.

However, the recommendations here should be considered a consensus of those present at the time these particular subjects were being

discussed. Ours I do have in final written form. I will hit some of the highlights of that report. The considerations and recommendations are considerably jumbled together, but I think it should be clear upon reading.

We first established for ourselves a working definition realizing that better qualified groups than ours had defined chronic illness which basically was our concern, special medical problems, but we did come up with a definition which we felt was understood by all of us as covering more or less generally the field.

One of the things we discussed was the fact we felt that perhaps there was the need for additional professional personnel in the regional offices of vocational rehabilitation in order to increase the effectiveness of these offices.

For instance, all of the regional offices do not have full-time physicians. We feel that a physician is essential on the rehabilitation team, vocational or otherwise.

An advisory committee to this office might plan and coordinate the services it sponsors and recommend developments, should review and approve all research and demonstration projects and study ways of improving the community and cooperation of those providing rehabilitation services.

I might say that these words, community and cooperation, recurred frequently during the course of our 2-day discussion, in many instances in such a way that certainly the legislation would not solve the problem, but we were more than conscious of the fact that there are breakdowns in the kind of cooperation and exchange of information between agencies, official and voluntary.

We cannot legislate to overcome this, but we should certainly all be thinking about it.

We feel that the provision of funds to publish the findings of research and demonstration projects is essential. There are instances where research projects are being done through private funds, from foundation and whatnot, and that these same kinds of projects have been repeated by someone else, someplace else, not knowing that the first one has been done.

We may be all guilty of this, but if there could be broader distribution of the findings of research projects we might eliminate duplication and help each other more.

We spent a good deal of time on the importance of research, many aspects of it, one of them the causes of chronic illness, finding causes of illness, opening avenues in preventing illness, and finding cures, also in the basic sciences, physics, chemistry, and so on.

The applied plans such as engineering have much to offer in the upgrading of rehabilitation services.

Many people with special medical problems have inadequate housing, nutrition, and medical supervision with expensive drugs being difficult for them to purchase. We felt that Federal grants to study these problems and to find ways of alleviating them should be made available to experts in these fields interested in doing research.

Although some States, notably Connecticut, in our discussion yesterday, seemed to have enough facilities—I emphasize the theme there was not complete agreement—the fact that there are some empty beds did not seem to me and to a couple of others, to indicate this means that we have facilities that we don't need. I think it is rather an

indication that there may be the need, but perhaps the people, the physicians, have not been educated to the fact that these facilities are available.

I think we could find the people to fill them.

Anyway, some States seemed to have enough facilities to provide comprehensive rehabilitation services, but the New England region as a whole did not. We felt that States without adequate facilities might perhaps make use of those operated by neighboring States and that there should be some way provided for the States to pay for the care for their beneficiaries in another State.

If this is one of our northern New England States where perhaps there are not enough patients to fill a large new institution, that there might be some arrangement whereby that State fund might pay for their beneficiaries in another State.

We do not know enough about the cost of providing rehabilitation services. We felt that a consistent, sound, cost-accounting basis might be explored such as has been established by the Connecticut Hospital Association in this State.

All of the hospitals in Connecticut work on these same cost-accounting bases.

We feel that they have realistic figures available to know exactly what services cost how much and we would suggest that some exploration be done in the rehabilitation line that we might come up with the same kind of figures.

Handicapped people primarily deal with the long-term things, cerebral palsy, mental retardation, who are housed with their families in their homes, sometimes find their families unable to take care of them.

For instance, because of the temporary illness of one of the parents or even as the cerebral palsy individual, or one with mental retardation becomes older and the parents die, there needs to be some way to take care of these kinds of people on a temporary basis if it is a temporary disruption of the home or on a more permanent basis, where necessary.

We felt that the facilities of the program to foster home care might be developed to provide this kind of service. There are sufficient number of cases to warrant a federally sponsored study of the problem.

We would hope that such a study might produce suitable legislation.

The subject of personnel was another one that got a great deal of discussion time. With the increasing problem we feel they cannot be resolved without an increased number of personnel in the various disciplines involved in the rehabilitation team. We feel that Federal grants to universities and other training facilities to enlarge their faculties by addition of specialists in this field are strongly recommended, that scholarships should continue and that there should be more of them for worthy students interested in the field.

Assistance might also be given to rehabilitation facilities that are willing and able to give their clinical training to these people that Federal grant to such agencies might serve as an incentive to them.

We also felt that more emphasis might be given to the nonprofessional personnel similar to the nurses aid programs that the nurses have done so well with.

We felt it was desirable to have these aids as soon as possible. And that a study should be made to delineate the areas of responsibility for professions in this field, meaning by this that there should be a distinct delineation of work that might be done by the professionals such as the occupational therapist or the physical therapist but an aid could assist her in a less professional activity, but there should be a clear distinction as to who may do what.

On the subject of the insurance, the insurance carriers do not pay for vocational training; therefore, we felt there might be a better liaison in cooperation by physicians, insurance carriers, and vocational rehabilitation personnel.

On the disabled who are applying for total and permanent disability, most of these seemed to be very poor candidates for rehabilitation as far as the goal for reemployment is concerned.

However, we learned from experience that some of them so upgrade their abilities that the goal becomes more practical.

In addition, many disabled could live with less dependency if rehabilitation services were paid for.

In addition to humanitarian values, such provisions would save money because fewer custodial personnel would be needed.

More of these handicapped people would be able to live with dignity among friend and family if such services were provided.

We felt that a criteria such as the feasibility of employment might well be eliminated in determining eligibility for Federal and State rehabilitation services.

Rehabilitation of the disabled by rehabilitation teams often points to unexplored yet highly productive avenues for the handicapped individual. These are expensive services with a number of skilled personnel necessary to undertake them.

Therefore, we feel that grants to stimulate this service are desirable.

The last point which we make is that assistance to evaluate rehabilitation potentials would be welcomed by a majority of the convalescent hospitals in Connecticut. We need two or three representatives from our convalescent hospitals or nursing homes and they are **extremely interested in the problems of rehabilitation.**

There was general agreement that it is more economical to provide funds for rehabilitation than it is to maintain the disabled individual.

There was considerable discussion of the current formula for making grants to States for vocational rehabilitation, currently on a closed end basis.

It was recommended that such funds be made available to States on an open-end basis, as they are for public assistance programs.

Mr. ELLIOTT. Thank you very much, Mrs. Howe, for that very fine report.

WORKSHOP REPORT ON SPECIAL MEDICAL PROBLEMS

(Dr. Sterling B. Brinkley and Robert J. Van Wart, cochairmen)

INTRODUCTION

Thirty-six experts in medical affairs from the New England region participated in one of seven sections of a special education and rehabilitation study sponsored by the Subcommittee on Special Education of the Committee on Education and Labor of the U.S. House of Representatives.

This study was conducted at Yale University on December 15 and 16. The section was asked to consider the needs of the citizens in this region who are handicapped by special medical problems; to review how these individuals are currently assisted by federally sponsored health and welfare programs; and to consider how they could be even more effectively assisted by additional federally sponsored programs.

The participants have experience and training in many of the disciplines concerned with rehabilitation. Unfortunately all of them could not attend all of the sessions. Therefore, the following recommendations are the consensus of those present when the problem referred to was being discussed.

Considerations and recommendations (a summary)

1. Special medical problems were defined as the problems of people who are disabled physically and/or mentally for a prolonged period; people who need comprehensive coordinated services and/or facilities to restore their abilities so that they may live with dignity and self respect.

2. The regional office of vocational rehabilitation needs additional professional personnel to increase its effectiveness (a full-time physician, for example). An advisory committee to this office should plan and coordinate the services it sponsors and recommend developments. It should review and approve all research and demonstration projects and study ways of improving the communication and cooperation of those providing rehabilitation services.

3. The provision of funds to publish the findings of research and demonstration projects was suggested.

4. Research: Of primary importance is research into the cause of chronic illness. Epidemiological research, together with finding the cause of illness opens avenues to preventing illness and to finding cures. Also, basic sciences (physics, chemistry, math) and applied science such as engineering have much to offer in the upgrading of rehabilitation services.

5. People disabled by one disorder are, of course, doubly handicapped if complications relating to their primary handicap develop. Many of these complications could be prevented if health services applied what is now known. Programs to this end are essential. All measures to protect the handicapped individual avoid additional unrelated handicaps should also be encouraged.

6. Many people with special medical problems have inadequate housing, nutrition, and medical supervision. Drugs may be too expensive for them to purchase. Federal grants to study these problems and find ways of alleviating them should be made available to interested experts in these fields.

7. Although some States, notably Connecticut, seem to have enough facilities to provide comprehensive rehabilitation services, the New England region as a whole does not. States without adequate facilities should make use of those operated by neighboring States and pay for care provided their beneficiaries.

8. Costs of providing rehabilitation services are not generally known. Sound, consistent cost accounting such as that now used by all of Connecticut's general hospitals is essential if States are to relate realistically the cost of service to the results obtained.

9. Handicapped people, notably those with cerebral palsy and mental retardation, who receive housing and custodial care by their families in their homes may find their families unable to continue caring for them.

Facilities or programs of foster home care should be developed to provide this service. There is a substantial number of such cases, therefore a federally sponsored study of this problem is warranted. Such a study should bring forth suitable legislation.

10. The increasing problems of rehabilitation cannot be solved until a large number of trained personnel becomes available. Therefore, Federal grants to universities and other training facilities to enlarge their faculties by the addition of specialists in this field are strongly recommended. Scholarships for worthy students interested in this field are also desired. Assistance should also be given to rehabilitation facilities willing and able to give clinical training to these people. Such Federal grants may serve as an incentive. Many types of rehabilitation services can be provided by people who have not received extensive formal training. It is desirable to have aids assume as many responsibilities as possible and a study should be made to delineate areas of responsibility for professions in this field.

11. Insurance carriers do not pay for vocational training. Therefore, ways of establishing better liaison and cooperation by physicians, insurance carriers, and vocational rehabilitation personnel should be encouraged.

12. Of the disabled applying for assistance because of total and permanent disability, few seem to be good candidates for rehabilitation with the goal of employment or reemployment. However, some of these people are found to so upgrade their abilities that such a goal becomes practical. In addition, many of the disabled could live with less dependents if rehabilitation services were available and paid for. In addition to considerable humanitarian values, such provisions would save money because fewer custodial care personnel would be needed by these people. More of these handicapped people would be able to live with dignity among friends and family if such services were provided.

Criteria such as feasibility of employment should be eliminated in determining eligibility for Federal-State rehabilitation services.

Reevaluation of the disabled by rehabilitation team often points to unexplored yet highly productive avenues for the handicapped individual. Reevaluation services are expensive because a number of skilled professional personnel provide such a service. Therefore, grants to stimulate this service are desired.

13. Assistance to reevaluate rehabilitation potentials would be welcome by a majority of convalescent hospitals in Connecticut.

Ways and means of developing this service should be explored.

14. Policies sold by commercial insurance companies are dramatically increasing the numbers of people protected from financial catastrophe. Blue Cross also is studying how they too can pay for prolonged illness while maintaining their solvency.

Participants in order of attendance:

Name and affiliation:

Alice Marshall, Connecticut State Employment Service, New Haven.

William Woods, Meriden Rehabilitation Center, Connecticut.

Ruth Curtis, united community services, Boston.

A. Ryrie Koch, office of vocational rehabilitation, Northeast Region, Boston.

Mary Brown, Yale University Department of Public Health.

Vera Arterburn, Connecticut Chronic and Convalescent Hospital, association secretary.

Theodore Hawkins, Connecticut Chronic and Convalescent Hospital Association.

Sterling Brinkley, Gaylord Farm Sanatorium, Wallingford, Conn.

Robert VanWart, Bay State Rehabilitation Center, Springfield, Mass.

I. W. Scherer, Veterans' Administration, Northampton, Mass.

Michael Marcinkowski, Veterans TB and Health Association.

Stuart Knox, Connecticut Hospital Association.

Edith Olson, Yale University School of Public Health.

Elizabeth May, dean, School of Home Economics, University of Connecticut.

Anthony Suchy, Connecticut Blue Cross.

Philip Schneiderman, United Cerebral Palsy of Western Massachusetts.

Kathleen Howe, New Haven Area Rehabilitation Center.

Horace Brown, Connecticut Heart Association.

D. Guiliano, Consultants, Inc.

M. Pringle, Colonial Convalescent Hospital.

Bess Lande, public health student, Yale.

G. H. Riopel, bureau vocational rehabilitation, Hartford, Conn.

Helen T. Watson, Connecticut State Department of Education, Hartford, Conn.

Pauline McCready, Crotched Mountain Rehabilitation Center, New Hampshire.

John Allen, M.D., Newington Hospital for Crippled Children, Connecticut.

J. Meigs, M.D., Yale University Department of Public Health.

John Gallivan, M.D., United Aircraft, East Hartford, Conn.

James Miller, State health department and medical society, Hartford, Conn.

H. Stoppels, Aetna Life Insurance Co., Hartford.

Samuel Deich, Colonial Convalescent Hospital, Glastonbury, Conn.

H. Barrett, State department of health, Connecticut.

M. Horton, executive director, Connecticut Medical Service.

H. Biechan, Connecticut Medical Services, New Haven.

Ray Grey, community council, Bridgeport, Conn.

J. Peters, State bureau of vocational rehabilitation, Connecticut.

Ira Hiscock, Yale University, Department of Public Health, Hartford.

May I thank you, Dr. Gall, for a very successful workshop.
Our next witness is Miss Ethel D. Mecum, superintendent, Long Lane School, Middletown, Conn.

STATEMENT OF ETHEL D. MECUM, SUPERINTENDENT, LONG LANE SCHOOL, MIDDLETOWN, CONN.

MISS MECUM. I would like to speak, if I may, for Royce Rocklin, who represents the training school for boys and who is president of the men's superintendent conference, and who said that Mr. J. B. Hill, of Alabama, had been appointed by the men's conference to represent all of these boys' training schools.

I am president of the National Association of Training Schools and junior agencies.

I think perhaps what I say in this statement may apply to the field nationwide.

The State training schools have one of the most difficult, as well as most challenging, of all types of work with children. Unlike private agencies and institutions, we must accept every child committed by the juvenile court, whether or not we have room or are equipped program-wise to meet the child's particular needs. The school becomes a sort of catchall, with a wide range of age, intelligence, ability, and types of problem.

Often the training school fails to receive the understanding, sympathy, and support of the public which is given agencies working with nondelinquent children—retarded, blind, crippled, et cetera—as the public demands that delinquent behavior be curbed and controlled without looking behind the overt behavior for its causes.

We know that delinquent behavior grows out of a variety of unmet needs of the child. The delinquent is usually an unhappy child, often rejected by family and community, usually a problem in school, usually with very low self-esteem.

The institution is charged with providing a setting combining controls, protection, training, and education—round-the-clock living.

The school must provide satisfying relationships and experiences and help the child to develop inner controls and the ability to again live in a community situation in a socially acceptable fashion.

Our children for the most part come from the lower economic and social group and are woefully lacking in general information as well as socially deprived. They have moved from school to school, and have been lost educationally, developed dislike of school probably because of lack of success and satisfaction, truanted, and because of nonconformity in the classroom have been endured by the teachers or suspended.

The program must be flexible and offer a large variety of educational opportunities, and the teachers must be better than the best, if these public school misfits are to find a security and develop self-confidence. Teachers must understand children as well as subject matter.

It is our feeling that children should not be penalized educationally because of prior behavior difficulties: that they have a right to a new chance.

Our elementary teacher with 21 children working at different levels from grades 5 through 7, received into her class the other day a

15-year-old, 6 months pregnant, described in her social history as a psychiatric problem from age 5, angry, moody, aggressive, unable to get along with her peers, had spent 2 years in a private child-caring institution, rejected by an immoral mother, has made more than one suicidal attempt, was sent home from a maternity home because of failure to adjust, refusal to eat, and threatened suicide.

This child wrote the following letter to her teacher at the end of the first day in our school:

The first room I went to was the library. Then the principal came and showed me to your classroom. The first things I seen was the Christmas things on the windows and the boards. It was a happy thing. That was when I knew that school would be pleasant this year for me.

This is an unattractive, unwanted child, who had been expelled from each school she had attended. Her new teacher is challenged to help her succeed in life as well as in the classroom.

Another child writes the same teacher:

Thank you for helping me in school and showing me how to be a good girl. Thank you for showing me the wrong things and the right things. I thank you so much for wasting your time to help me to learn.

This from an aggressive youngster who had terrorized the children in the school and neighborhood from which she came.

These cases are not isolated ones, by any means.

To better meet the tremendous needs of these youngsters we need:

1. Expansion of program to give greater variety—a modified shop setup and additional opportunities for the theory of homemaking. Practical courses are offered in cottage life program.

2. Reading specialists on high school level to work with the 40 percent who have reading problems which are causing failures in other learning areas.

3. Remedial and developmental teachers to plug the holes in basic learning and to offer special help to the small percentage of very bright students.

4. Summer school for students to be given the opportunity to make up deficiencies in order to have sufficient credits to be up to grade when they return to public school.

5. Full-time psychologist.

6. Dramatics, dancing, swimming instruction. These areas are no longer felt to be luxuries, but necessary therapeutic agents.

7. Funds for substitute teachers when regular teachers are ill.

8. Greater understanding and acceptance of students when they return to public school.

9. Funds for boarding-home care for those girls who are not capable of earning board and room while attending school.

It is understood Federal funds have been made available in some States for pilot projects such as the above. We seem unable to stretch our budget to meet the above educational needs.

I would like to ask if funds are made possible that in some way the delinquent children are not left out in this State at least. The child welfare funds all go to the commissioner of welfare. Somehow they never seem to reach the delinquent child, although they may have been under care of the commissioner of welfare. They do not reach out after the child has become labeled delinquent and comes to us.

Thank you very much.

Mr. ELLIOTT. Thank you very much, Miss Mecum. Your statement will be very helpful to the committee.

Miss MECUM. Thank you.

Mr. ELLIOTT. Our next witness is Pauline I. McCready, director, Crotched Mountain Rehabilitation Center, Greenfield, N.H.

STATEMENT OF PAULINE I. McCREADY, DIRECTOR, CROTCHED MOUNTAIN REHABILITATION CENTER, GREENFIELD, N.H.

Miss McCREADY. Mr. Chairman, members of the subcommittee, I wish to apologize for the fact that the U.S. mail has apparently mislaid our prepared material, and, once it catches up with it, may we have permission to send it to you and have it entered into the record?

Mr. ELLIOTT. Without objection, the prepared statement of Miss McCready will be made a part of the record, immediately following her oral presentation.

Miss McCREADY. I have culled out some notes from that material which I would like to present today.

We are very pleased to have the opportunity to present to you the need for rehabilitation of the physically handicapped as we have found them in our center at the Crotched Mountain Rehabilitation Center, Greenfield, N.H.

Mr. ELLIOTT. Would you tell us about that rehabilitation center, Miss McCready?

Miss McCREADY. I will be delighted.

To briefly identify it—because it is rather unique—I might point out that although it is located in New Hampshire, it has become a national institution, or a national organization, I should say.

It is a private, nonprofit organization which offers inpatient rehabilitation care.

It also cuts across not only State lines but we have children now from 23 States and 4 foreign countries as inpatients.

It also cuts across every disability which is handicapping, which includes all the neuromuscular, orthopedic, the deaf, the blind, and so forth.

Our adult rehabilitation center, which is to be opened in the next few months, and which has been delayed opening because of the steel strike, is also going to be on a regional or even national basis, rather than a local basis because we have had letters from all of the United States in the past 4 years, from persons and their families and physicians and organizations, asking for it to be opened to provide the comprehensive services which they cannot seem to get any place else.

Now, we call ourselves a comprehensive program, and I think it is. Our staff is composed of physicians, nurses, social workers, physical therapists, occupational therapists, speech therapists, recreation workers in special education, psychologists, and in our school for the deaf course training teachers for teaching in the schools for the deaf.

Every one of our staff is professionally accredited and each one of our departments is fully accredited professionally.

The adult center is going to include all services which are now being offered in the children's center.

In addition it is going to offer a complete program of vocational counseling and vocational training in a variety of industrial trades, white-collar jobs, and farming.

Furthermore, we expect, in fact we intend, to take the adult handicapped through to job placement whether it be in their home community which, of course, is what we hope for, but if not, for one reason or another, we will employ them at Crotched Mountain in the various shops which are being established there.

In addition, we are now operating a limited research program within the children's center, and we have a professional training program for which we are accredited in every professional discipline through our affiliation with schools of nursing, colleges, universities, and also we are accredited by an exchange visit or program by the U.S. Department of State.

Mr. ELLIOTT. How many people do you have?

Miss McCREADY. At the moment we have 85 beds in the children's center, which we badly need to expand. I have been hearing during these workshops for the past 2 days that inpatient centers throughout the country are going with empty beds. This is not our experience. Ours are full, and we have a waiting list. We need to expand.

We are trying to as soon as we can get the funds.

Mr. ELLIOTT. What is your position?

Miss McCREADY. I am the director, sir. The adult center will start small and grow as we can.

Mr. ELLIOTT. How is your institution supported primarily?

Miss McCREADY. We have endowments. We have a million dollar endowment for the children's center and \$2 million endowment for the adult center.

We have services throughout the State of New Hampshire.

We also have an annual appeal which we conduct. We have tuition payments from the various school districts, a lot of contributions come in, and then a variety of things of that sort.

So that all together we get it here and there and although once in a while it is a struggle, which is one of the things I would like to point out, the reasons for the struggle and some of the needs that we see.

Mr. ELLIOTT. Of course, I might say if interest rates keep going up those endowments will help a great deal.

Miss McCREADY. Of course they will help considerably. When you start working with the handicapped there is no question but what there are unlimited needs.

I don't know who can solve all of them, but in our experience we have picked out four or five major needs which we see which I would like to emphasize today.

The first one is funds for construction of the facilities for comprehensive rehabilitation programs.

In this respect I would like to refer to the proposed plan for area rehabilitation centers because that is precisely one of the reasons why Crotched Mountain was established.

We hoped that at Crotched Mountain we would demonstrate the need for and the value of the comprehensive rehabilitation center and that similar centers or facilities would be established throughout the United States.

It is our feeling that if they were that the need of the physically handicapped would be taken care of to a much greater degree than they are today.

However, the cost to build a facility of this kind is very expensive. You might be interested to know that at Crotched Mountain we have already raised \$4 million for building costs alone from private sources. We are presently engaged in raising \$1,200,000 for building costs.

Now, we have had to date \$150,000 from the Federal Government to assist in these costs and we have had approved recently an allocation of \$200,000 for this purpose. We have not received it yet.

Our adult center would have been opened long ago if we had had access to Federal funds and had not had to spend so much time traveling the country, getting private sources to give the funds for this.

We really think that if area rehabilitation facilities are established that Federal funds for the construction are going to be very necessary and one of the most difficult things to get from private sources.

The second need that we see is funds to purchase treatment. Rehabilitation is an expensive proposition as you know. Our costs fortunately have been lower than most.

Our present fee in the children's center is \$21.50 a day. You know that is but little more than you pay in the hospital for nothing except your room.

This includes all the services that we offer.

Although the Federal Government matches the State funds, for example, for treatment for the children, many States are not able apparently to provide sufficient funds to take care of the crippled children within that State that need treatment.

I can tell you that in New Hampshire this year the funds from New Hampshire which are matched by Federal funds are going to be exhausted on December 31. This means that for New Hampshire children alone we have to scramble around and find approximately \$100,000, possibly more, just to provide rehabilitation for the handicapped children of New Hampshire.

The year before that when they were exhausted it cost us \$71,000, and the year before that it cost us \$68,000.

We have to get these funds from private sources. Some way we feel that there should be a way, if the States are not able to provide the funds which the Federal Government would match, that there should be some way to get additional Federal funds to take care of these children.

Insofar as the children from other States are concerned, there are very few States in our experience, only one or two at the most, have been willing to pay for services for their children outside the State of residence, and we would like to suggest that some kind of legislation perhaps be afforded to handle this case again with all these youngsters from 23 other States, including one boy, I might add, from your State, Mr. Chairman. We have had to find private funds to take care of them and to give them the treatment that they need.

When it comes to programs for adult handicapped, I think probably the same situation will exist.

It appears that again we are going to have to find funds, provision for greater Federal participation when it crosses State lines and when the States themselves are unable to provide the funds.

I think that one thing I have not heard pointed out today is that within the United States approximately 2 percent of the total population of the handicapped received last year any rehabilitation services whatsoever.

Of that 2 percent, there were only a very few who received a total comprehensive program of rehabilitation which met all their needs.

That, perhaps, demonstrates the picture a little more. Because it is getting late, I am not going to go into too much more here except that insofar as professional training is concerned, we are operating affiliation for professional training.

The universities, the schools and the students going to the schools, can get a certain amount of funds. It may not be enough that they are getting some, but in our situation and in any situation which is similar to ours, there is not one thing, not one nickel available to help us take care of these students, but it is expensive to us.

We have to provide clinical instructors. We have to provide educational materials such as books, libraries, and so forth, and we must provide their living quarters while they are in residence.

We have to provide all this, ourselves, because there are no funds available.

I think that another thing insofar as research is concerned, the only thing I will say there is that funds are needed for applied research which can be carried on within the facility which is handling the actual programs of service to persons.

Now, as I said, these needs for the handicapped are almost unlimited. It may be heresy to say this, but we question whether the Federal Government should be asked to take care of all these needs. In our opinion there are private funds which are available which will meet, almost are meeting, as a matter of fact, many such needs.

We have found this to be true over and over again.

We would like to make, if we may, a suggestion that when this study is completed, or while it is going on, that certain priorities be established which will be a very difficult job to do, I know, but that priorities of need be established and that it is those priorities which Federal funds be used for.

We think that in our opinion the priorities for funds should be given to the construction of the necessary facilities and funds for purchase of the services within those facilities.

If that is done, we believe that many of the other problems are going to iron themselves out and we think that private funds from a number of different sources can be found to help with many of the other problems which are present.

Thank you very much.

Mr. ELLIOTT. Thank you, Miss McCready, for your testimony here.

Our next witness is Mr. Stanley Newman, chief psychologist, Clifford W. Beers Guidance Clinic, New Haven, Conn.

STATEMENT OF STANLEY NEWMAN, CHIEF PSYCHOLOGIST, CLIFFORD W. BEERS GUIDANCE CLINIC, NEW HAVEN, CONN.

Mr. NEWMAN. I am concerned with emotionally disturbed children. Actually, this is a disability that in many ways is more crippling in the community setting than physical disability.

There is a clear need for psychiatric treatment for emotionally disturbed children, both for those who have a physical disability and those youngsters who are physically well but socially disabled.

These children mildly to severely disturbed, on seeking this service, usually find it immediately unavailable, nonexistent, or only available after prolonged waiting periods. Even when children are placed on a waiting list the clinics are aware that the need for evaluation or treatment is immediate.

At a time when the demand has increased, the Clifford Beers Guidance Clinic has had to close its intake rather than expand because of insufficient community and State funds.

Many hours of intensive observation and diagnostic study are required to properly prepare a child and his family for psychiatric treatment. This treatment must of necessity be long, since it takes many years for maladaptive behavior to occur in a child. It is impossible to eradicate or greatly reduce this behavior in a brief period. Years of developing illness must be met by at least a sufficient number of psychiatric hours.

Under these conditions a psychiatric clinic could not possibly see vastly larger numbers of children without a parallel increase of funds and facilities.

In addition, there is a great need for research, training of personnel, and community education, as well as the services outlined above.

These essential activities are intrinsic to a guidance clinic, but have not been met due to insufficient funds. These activities are often unfortunately sacrificed to the immediate need for treating children yet, in the long run, are actually essential for the increased understanding and efficiency of this treatment.

There is a related major problem in this area concerning acutely disturbed children who need short term psychiatric hospitalization. However, these specialized children's wards do not exist and the children must be seen on an outpatient basis; at best, a poor substitute for adequate observation, care, and treatment.

The various outpatient agencies in the area need a hospital facility to take over the short term emergency care of these children.

When these kids are seen at our own clinic, they take up a great deal of effort and time and in this way deny treatment to those who can be treated more efficiently. They must be seen within a very controlled setting and we don't have the setting within the area.

The consequence of inadequate child psychiatric care is grave. It means an increase in problems for the local schools in managing these children, particularly since learning is frequently blocked.

This loss of human resource is irreplaceable. The consequences for future mental health is likewise grave in view of the fact that adult disturbance frequently results from unresolved emotional problems in the growing child and adolescent.

Thus, it is firmly felt that the best way to attain normal, sensible living in adulthood is to prevent disturbances from developing in children. In order to accomplish this, the needs outlined above should be adequately met.

In addition, I want to make a brief comment about research. This has been mentioned many times today. I think it has been mentioned so often because of its crucial nature.

Specifically, we need research to understand how to shorten and make more brief our treatment of these children. It is true in hearing, it is also true of the psychiatric area, too.

We must understand ways of getting other individuals not fully professionally trained; for example, teachers, to deal with emotional problems in kids in ways that can help alleviate this problem instead of leaving it only up to the individual guidance clinic. This requires understanding and requires research and, of course, this requires funds.

There are NIH funds, but I think it would be very helpful to supplement these funds with specific grants in aid and also incentives to the various clinics and also to the universities and clinics working together to install this kind of research.

Also, there is a specific need to train professional personnel within the actual clinic setting rather than the school; in schools usually you have the academic training internships. These internships are generally required within clinics, hospital settings, and so on. We don't have the personnel to train these people.

We have to have specific grants in order to pay supervisors and people or in order to provide facilities to train these individuals.

We have the facilities in schools to train them, but we must place them somewhere. We have to have the clinics and expanded facilities.

As a last point I did want to mention something in terms of Federal aid. I think many people have often questioned the advisability of the Federal Government giving aid. They sort of say, Why put the bite on us. Why don't the State and local communities take care of this?

I think there is another good reason why the Federal Government should step in. When there has been a Federal grant to work out a particular problem in an area it has given such impetus to this problem that the community suddenly becomes aware of the grave nature of it, that their own national office has taken part.

It is interesting to note once this has been done many of the States and local communities want to cooperate to increase their own understanding and their own funds.

Often there is no awareness until the Federal Government puts the finger and focuses upon a very grave problem.

Then you get additional funds. I think in the long run this will relieve the pressure upon Federal funds because the funds are given as a result of impetus by the Federal Government.

Mr. GIALMO. Dr. Newman, you said that the consequences of a lack of adequate child psychiatric care could or would be very grave. Are we in danger of running into that situation in this area?

Mr. NEWMAN. Yes, in this area.

For example, specifically in the Beers Clinic—and we are really one of the two community clinics within this area—our waiting lists have increased tremendously. Waiting lists are about your best indication of the need.

It is interesting to note that many kids never even get on the waiting list because the people feel, well, they will not take care of us for a year, so they won't go.

These are the people that need to come in at that moment. It is increasing year by year.

Even though our professional staffs have increased, they have never been able to keep up with this.

Mr. GIAIMO. So we are running into this shortage problem?

Mr. NEWMAN. Yes; the shortage is acute. If you can draw a draft, you find as your personnel increases they can never keep up with the rise on the graph on the incidence of emotional disturbance and, of course, adult disturbances, too.

Mr. GIAIMO. This ties in also with the fact that there is a shortage in research and trained personnel because of lack of funds?

Mr. NEWMAN. Yes. Many, many people have kept away from these areas of psychiatry, psychology, and social work because there were not sufficient training programs in the schools because of insufficient funds. Once they get in the area, there is no incentive to stay in, because if they are interested in research and understanding why these things occur they can't get any money for it. There is no blame involved. It is just the conditions.

These people generally shift out of the area. So we cannot increase the personnel we need enough to keep up with the growing demand. Many people felt, well, these people were always disturbed—we just never spotted them.

I don't think that is true. I think as a result of the increased difficulties of living that we have today a lot of these emotional disturbances are being triggered off and we have to take care of them.

Mr. GIAIMO. What facilities are there for child psychiatry in this general area here other than your own?

Mr. NEWMAN. We have the Child Study Center, which is affiliated with Yale University, which is similar to our clinic in terms of helping kids with emotional disturbances. They tend to function more as a training and research center, and also in this process, of course, provide service for the kids.

Outside of our two clinics there are no other clinics in the area except those related clinics, family service clinics, and so on, who in their process of helping do, of course, give psychiatric aid, but are not set up to give continuous psychiatric aid.

Thank you.

Mr. GIAIMO. Thank you.

Mr. ELLIOTT. Thank you very much, Dr. Newman.

Our next witness is the Reverend Joseph Pouliot, Goodwill Industries of New England, Bridgeport, Conn.

STATEMENT OF REV. JOSEPH POULIOT, GOODWILL INDUSTRIES OF NEW ENGLAND, BRIDGEPORT, CONN.

Reverend POULIOT. In view of the lateness of the hour, Mr. Chairman—and I am sure you and your committee are tired by this time—rather than to read the whole presentation that I have, if I might, I would like to give it to you, and then I will just point up two or three of the items that were not touched on so far as I know this afternoon.

Mr. ELLIOTT. Without objection, the full statement of Mr. Pouliot will be placed in the record following his oral presentation.

Reverend POULIOT. Aside from the opening remarks relative to the worth of such legislation as might come out of these sessions supporting the rehabilitation services not only in New England, but all over the country, I would just like to cite the experience of the Goodwill Industries of Bridgeport, who participated in the act of 1954 as administered throughout the Office of Vocational Rehabilitation.

We received some \$14,000 in expansion grants for the service to the handicapped of the Greater Bridgeport area.

It was interesting to me in preparing this presentation that a check of wages paid to handicapped people in the Greater Bridgeport area rose from a \$50,000 figure in 1954 and just prior to the receiving of this grant to an anticipated \$260,000 in wages for 1959.

Of course, along with this was training evaluation, other rehabilitation services, which cannot be measured in dollars and cents.

Obviously this expanded activity was due to the grant received but certainly you can take it from me it made a most important role in the development of this rehabilitation center in Bridgeport.

I am just going to give the headings of the six recommendations that we would like to see incorporated in any legislation.

Expanding educational program No. 1, for all segments, including the labor, management, general public, as well as the handicapped person who is in need of these services.

Item two, funds for training of personnel at the professional and managerial levels.

Item three, need for funds for the development and implementation of workable, meaningful evaluation services.

Item four, funds for modern adequate facilities and equipment as may be needed.

Two items I particularly felt had not been touched upon and feel this is a logical development of the first four. It is logical that funds for improved means of transportation be included in the legislation.

Although we provide all of the above services and facilities it is imperative that we make it possible for the handicapped persons to avail themselves of these services.

Present bills providing for transportation are not adequate to assist many of the severely handicapped. This might include the need of special equipment such as the so-called lifemobile, which is a small bus type vehicle with hydraulic lift.

Proper transportation equipment certainly would transform a homebound handicapped person to a well adjusted productive member of society.

Item six is the need for revision of the Federal Property and Administration Services Act of 1949 to include nonprofit rehabilitation agencies especially in the light of the fact that some two million dollars worth of surplus property was sold during the last fiscal year at approximately 5 cents on the dollar.

Some of these materials, such as desks, laundry and cafeteria equipment, radio parts, and so forth, could certainly have been used in assisting the rehabilitation facilities in their task.

In conclusion, the Goodwill Industry of New England are interested in supporting legislation such as this that will assist in the rehabilitation of handicapped persons.

Certainly we wish to thank you, Mr. Elliott and your committee, for hearing us this afternoon.

Mr. ELLIOTT. Thank you very much, Mr. Pouliot.

(The statement referred to follows:)

STATEMENT OF GOODWILL INDUSTRIES OF THE NEW ENGLAND AREA, BY THE
REVEREND MR. JOSEPH E. POULIOT, OF BRIDGEPORT

Mr. Chairman and committee members, my name is Joseph E. Pouliot, and I am the executive director of the Goodwill Industries of Bridgeport. I am here not only representing the aforesaid agency but also representing the Goodwill Industries of the New England area on behalf of the Goodwill Industries of America, the parent organization. There are eight Goodwill Industries in this area that I represent, located in Boston, Lowell, Lynn, Pittsfield, and Springfield, Mass., as well as Bridgeport and New Haven, Conn., and Portland, Maine.

I am not here to promote Goodwill Industries, for I'm sure all of you are well aware of the work that Goodwill Industries is doing on a national basis as well as in the New England area where Goodwill had its beginning. It has become the largest privately operated employment and training agency for the handicapped in this country.

My true purpose for asking for time to make this presentation was to point up the need for assistance to continue and expand facilities and services to the handicapped, as we of Goodwill see it, in an attempt to service as adequately as possible the greatest number of handicapped possible with the funds that are available. However, we, like most other agencies engage in the rehabilitation of the handicapped, are continually faced with the problem of numbers. These represent an unmet need because they present a particular problem. Of necessity their need is usually weighed against maximum results and funds available.

In many instances, local fund-raising efforts, whether it be through a united effort or through individual appeals, fall short of providing the necessary funds to make possible the adequate facilities and services needed to reach all the handicapped that could benefit from these facilities and services. Many are not even afforded that chance needed to instill within them that desire and motivation to take up their proper places in society. Why? Because available funds will not permit.

Certainly a good start was made in 1943 with the enactment of the Barden-La Follette Act, then followed by the Vocational Rehabilitation Amendment Act of 1954, as administered through the Office of Vocational Rehabilitation.

The Bridgeport Goodwill participated in that latter act and received a little over \$14,000, which made possible expansion of our services to the handicapped of our area. A recent check of wages paid to the handicapped of the Greater Bridgeport area reveals that in 1954 we paid a little under \$50,000 in wages and other compensation to the handicapped, and it is anticipated after completing 11 months that figure for 1959 will be approximately \$260,000. Along with this, of course, was training, evaluation, and other rehabilitation services that cannot be measured in dollars and cents.

Obviously, this expanded activity was not all due to the grant received; but, gentlemen, take it from me, it certainly played a most important role in this development. May I also say it was a good investment.

Legislation of this kind for providing funds for needed rehabilitation services, especially in creating services where they are absent (and there is sufficient need), and the expanding and upgrading of existing services is not an expenditure. It is the best investment the Federal Government could make. The handicapped individual who is a drain on public funds can in many instances be transformed to a self-respecting self-sufficient taxpayer if funds are available to give him that one chance, though the process may be long and hard.

It is not difficult to go on and on to truly justify funds for the rehabilitation of the handicapped, because it has proven its worth. So, now to get on with what we feel are some of the unmet needs.

It is apparent that there are many needs of equal importance, and they may vary widely within an area even between neighboring cities; however, we must leave determination of local needs and rather look at general, apparent needs and inadequacies.

(1) An expanding educational program, covering rehabilitation processes—including the vocational aspect of rehabilitation, and also covering the services available, geared to reach all segments of our population, is vitally needed.

Labor and management, as well as the general public, need to be exposed to this knowledge. The handicapped person, more than anyone else, needs to know just what he must do, as well as what can be done for him, to make proper and adequate adjustments.

(2) Funds for training of personnel at the professional and managerial levels to assure adequate upgrading of programs for the handicapped already operating and for new programs seem to be the only possible way of securing proper services both now and in the future. This could be attained through curriculum and scholarships, as well as on-the-job practical training, as in the case of vocational rehabilitation.

Education and training opportunities should also be provided for those unable to attain the levels aforementioned, with the idea of training to the highest level possible for that particular individual, whatever that level may be.

(3) A need for funds for the development and implementation of workable and meaningful evaluation services is most apparent on every hand, especially for the severely handicapped individual. Such services established since 1955 in Goodwill Industries have proved most successful. The lack of funds in many instances, however, limits our private agencies to clients "most likely to succeed." The person who is likely to reach a relatively low degree of development still deserves to know just that level is and be given services to make even that development possible.

(4) If there is a need for trained personnel and proper and adequate evaluation, it naturally and logically follows that a need for funds for modern, adequate facilities and equipment exists. In many cases, existing facilities could be utilized to a greater extent, improved, and expanded. Goodwill, by the very nature of its program already demonstrated, favors the type of facility that serves multiple types of disabilities. We believe this helps to breakdown psychological barriers that sometimes exist. We also believe that the voluntary agencies working together with the State and Federal Governments can accomplish the desired results in rehabilitation. The need for funds, however, for buildings, and equipment must be met through a joint program where the community provides all it can and is then supplemented through Federal funds.

(5) It is also logical that funds for improved means of transportation be included in legislation. Although we provide all of the above services and facilities, it is imperative that we make it possible for the handicapped person to avail himself of these services. The present bills providing transportation are not adequate to assist many severely handicapped. This might include the need for special equipment such as a so-called Liftmobile (which is a small bus-type vehicle with a hydraulic lift). Proper transportation equipment certainly would transform many a homebound handicapped person to a well-adjusted productive member of society.

(6) The need for revision of the Federal Property and Administration Services Act of 1949, section 203, to include nonprofit rehabilitation agencies, is also apparent, especially in light of the fact that \$2 billion worth of surplus property was sold during the last fiscal year at 5 cents on the \$1. Some of this material, such as desks, laundry and cafeteria equipment, chain falls, radio parts, etc., could have been used in assisting rehabilitation facilities.

In conclusion, the Goodwill Industries of New England are interested in supporting all legislation that will assist in the rehabilitation of handicapped persons.

The time is late and I wish to thank this committee for their time and efforts on behalf of the handicapped.

Mr. ELLIOTT. At this point I have a letter from Mr. Herbert D. Welte, president of the Central Connecticut State College, New Britain, Conn., dated September 16, and addressed to me, which includes his statement on the matter that this subcommittee is interested in at this time.

Without objection I will ask that this letter of Mr. Welte be made a part of the record.

(The letter referred to follows:)

CENTRAL CONNECTICUT STATE COLLEGE,
New Britain, Conn., December 16, 1959.

HON. CARL ELLIOTT,
Chairman, Subcommittee on Special Education, Committee on Education and Labor, U.S. House of Representatives, Washington, D.C.

DEAR MR. ELLIOTT: It is strongly recommended that Federal legislation be enacted for the support of programs of special education. If the Nation is to fully discharge its responsibilities for the preparation of all of its citizens to the limits of their capabilities, consideration must be given to the special needs of those who are physically or mentally handicapped. There seems to be four basic problems related to the need for the expansion of such services:

1. The public and its duly elected representatives, parents, or guardians of those who are in need of special training or education, as well as the individual himself, must be made aware of the responsibilities of a democracy to provide such special training. We must recognize the potential involved in the complete utilization of the human resources of the Nation and we must also recognize that additional funds are required if our full potential is to be realized.

Specifically, it is suggested that the Department of Health, Education, and Welfare provide the leadership in preparing authentic and documented information concerning the causes, the possibilities of correction, the responsibilities of parents and society, the aid which should be provided, the types of training available, and the adjustment of the adult to the community.

2. A suitable and comprehensive training program should be established immediately and should be made available to all of those who might profit from such training. Imagination and resourcefulness are necessary. Established patterns of education should be temporarily modified and curriculums altered. Certification requirements for the personnel to handle such program may need to be modified in an attempt to enlist the services of former teachers and to attract those whose education, although not specifically directed toward teaching, nevertheless have abilities in this field of special education which might be utilized.

Specifically, it is suggested that the Department of Health, Education, and Welfare develop, promote, and assist in financing: (a) in-service teacher training programs for former teachers and personnel from other professions who might become special education teachers; (b) intensive training and supervision for selected liberal arts graduates; (c) seminars and summer workshops to improve the professional competence of those attracted to the field as suggested above.

3. Policies and programs must be developed in such way that special education becomes a recognized responsibility of all communities.

Specifically, it is recommended that: (a) the present program of preparing teachers of special education needs to be greatly expanded; (b) the concept of training necessary to handle the problems of special students must be greatly expanded to include all of the resources of the community, including those professions with personnel of special abilities.

4. Through experiment and research, existing programs must be critically evaluated.

It is specifically suggested that the Department of Health, Education, and Welfare sponsor pilot training programs which would emphasize the multi-discipline approach and which would combine clinical services, laboratory experiences, and the training of specialists in all fields of special education, e.g., the very bright, the mentally retarded, the physically handicapped, the cerebral palsy, etc. It is believed that observation of all such special cases under a controlled situation might provide a key to the development of sound programs and techniques applicable to each type. Such program would necessarily expand the concept of education as suggested in 3(b) above and would require such special services as provided by a speech clinic, physical therapist, etc.

5. Finally, any comprehensive program should be based upon recognizing that in our society it is our collective responsibility to prepare every individual to his maximum capabilities, including those who are physically or mentally handicapped.

Respectfully yours,

HERBERT D. WELTE, *President.*

Mr. ELLIOTT. I have a letter from Mr. Frank Kowalski, a Member at Large of Congress from the State of Connecticut, stating:

I regret that I cannot be present for your hearings in Connecticut. For the consideration of your subcommittee I am submitting a statement of my views on the legislation with which your hearings are concerned.

The letter and the statement, without objection, will be made a part of the record at this point.

(The letter and statement referred to follow:)

HOUSE OF REPRESENTATIVES,
Washington, D.C., December 16, 1959.

HON. CARL ELLIOTT,

Chairman, Subcommittee on Special Education, House Committee on Education and Labor, Federal Courtroom, U.S. Post Office Building, New Haven, Conn.

DEAR MR. CHAIRMAN: I regret that I cannot be present for your hearings in Connecticut.

For the consideration of your subcommittee, I am submitting a statement of my views on the legislation with which your hearings are concerned.

Yours sincerely,

FRANK KOWALSKI,
Member of Congress.

STATEMENT BY CONGRESSMAN AT LARGE FRANK KOWALSKI, OF CONNECTICUT

Mr. Chairman and members of the subcommittee, we in Connecticut are grateful to you for arranging to hold hearings in our State on legislation with which many of our citizens are deeply concerned. I am sure that the hearings, and the workshop held in conjunction with them, will provide you with much valuable data.

I trust that your subcommittee will see fit to recommend a rehabilitation act, with its most laudable goal of "independent living." Only through the assistance of our National Government can the several States provide the programs which are so desperately needed to restore dignity and independence to the handicapped and the elderly who are now ineligible for vocational rehabilitation.

I also urge that you give favorable consideration to legislation to expand and improve teaching and training facilities for those with hearing and speech defects.

The experts in these fields are submitting technical testimony, but I know that you will also consider the tremendous human values that are involved. Your subcommittee can make a great contribution to America by recommending strong legislation in the two fields I have mentioned.

Mr. ELLIOTT. Now we have for tomorrow scheduled 40 witnesses.

In order that we may hear all of those witnesses tomorrow, it will be necessary, I think, that we begin at 9:30 in the morning. Is there objection to that?

We will begin at 9:30 tomorrow morning.

(Thereupon, 5 p.m., the hearing was recessed, to reconvene at 9:30 a.m., Friday, December 18, 1959.)

SPECIAL EDUCATION AND REHABILITATION

FRIDAY, DECEMBER 18, 1959

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON SPECIAL EDUCATION,
OF THE COMMITTEE ON EDUCATION AND LABOR,
New Haven, Conn.

The Subcommittee on Special Education met, pursuant to recess, at 9:30 a.m., in the Federal Courtroom, U.S. Post Office Building, New Haven, Conn., Hon. Carl Elliott, chairman of the special subcommittee, presiding.

Present: Representatives Elliott, Daniels, Giaimo, Wainwright, and Lafore.

Mr. ELLIOTT. At the beginning of our second day of hearings here in New Haven I have several statements for the record. First, I have from the Honorable James C. Oliver, a Member of Congress from the State of Maine, First District of Maine, a statement in behalf of the matters that we are studying here and at this point, without objection, I offer that statement for the record.

Second, I have from Dr. Frederick T. Hill, of the Thayer's Hospital, Waterville, Maine, a statement, dated December 8, urging the passage of House Joint Resolution 316.

Third, a statement from Harold N. Willard, director of rehabilitation, Thayer Hospital, this statement being in regard to the independent living bill.

A letter from Robert E. Belyea, dated December 17, 1959. Mr. Belyea is the director of educational therapy of the Institute of Living, Hartford, Conn.—together with a paper with respect to the general problems that we are studying.

Next is a statement from Dura-Louise Cockrell, dated December 14, 1959, addressed to me.

Next is a statement by Katharine C. Cotter, coordinator of program of special education, Boston College School of Education, Boston, Mass.

Next is a letter addressed to me from Gray H. Curtis, executive director for the department of education, vocational rehabilitation division, Augusta, Maine, dated December 11, 1959.

With it is a copy of the letter he has written to the Honorable Margaret Chase Smith, U.S. Senator from Maine.

With it also is a statement with respect to the unmet needs of the handicapped in Maine.

Next is a letter dated December 15, 1959, addressed to me, from Miss Kathleen Kirby, executive director of the Worcester County Hearing and Speech Center, Inc., Worcester, Mass.

(The documents referred to follow:)

TESTIMONY BY HON. JAMES C. OLIVER, MEMBER OF CONGRESS (FIRST DISTRICT, MAINE), IN SUPPORT OF LEGISLATION TO PROVIDE FOR (1) TRAINING TEACHERS OF THE DEAF, SPEECH PATHOLOGISTS, AND SPEECH AUDIOLOGISTS, AND (2) INDEPENDENT LIVING LEGISLATION

Mr. CHAIRMAN. The two topics, which your distinguished subcommittee is considering today, graphically illustrate one of the most serious problems we face as a Nation. The United States cannot continue to permit the needless loss of its human resources. Funds expended to rehabilitate physically handicapped children and adults constitute an investment which will pay for itself many times over in terms of reclaimed lives and positive contributions to our society.

In my State of Maine alone, it has been estimated that there are 11,645 speech and 5,169 hearing defects which remain undiscovered in school age children. Many of these children may have been mistakenly identified as retarded, when in fact their inability to comprehend can easily be remedied. The problem lies in detection. Unfortunately, there is an appalling lack of trained technicians who are capable of recognizing the existence of hearing and speech deficiencies. If we expect to meet the problems of the 8 million American citizens handicapped by speech and hearing defects, a total of 20,000 speech pathologists and audiologists are needed rather than the presently inadequate 2,000 certified to deal with these problems. In addition, there is an annual need for 500 teachers of the deaf while we are presently educating only 150 each year.

The legislation under discussion would go a long way toward meeting this deficiency. A relatively small total of \$3.5 million would directly result in the rehabilitation of the vast majority of the 8 million Americans who are presently incapacitated. Through Federal grants to public and nonprofit institutions engaged in training teachers of the deaf, we can enable many physically handicapped Americans to live normal, productive lives.

My distinguished colleagues, the chairman of this subcommittee and the gentleman from Rhode Island, Mr. Fogarty, have introduced important legislation which would revitalize our Federal vocational rehabilitation program. One change that they propose in existing law is particularly significant. At the present time, a physically handicapped individual may only receive assistance if there is a reasonable expectation of his future employability. The bill which the committee is now considering would extend assistance to those handicapped individuals who can achieve a degree of independence which will enable them to dispense with expensive hospital or private medical care. Experts in this field agree that this extension of rehabilitation service would in fact bring about the vocational rehabilitation of many for whom there was felt to be no hope.

The legislation under discussion also provides for the expansion of existing rehabilitation facilities, into fields such as the establishment of workshops for the mentally retarded, mentally ill, and cerebral palsied. A modest sum is also proposed for allocation to the President's Committee on the Employment of the Handicapped. This committee has done an excellent job in publicizing the need for employment of the physically handicapped, but desperately requires and additional annual appropriation of \$75,000 to expand its informational activities.

I strongly urge passage of the legislation which is under consideration here today. Enactment of these bills makes sense not only from the point of view of the individuals concerned but from the national standpoint as well. In these days when the United States is faced by a serious external threat, all available manpower is needed. By refusing to enact this legislation, we are, in effect, denying our country the efforts of men and women who have the talent to contribute constructively to our Nation. We not only can, but must, restore the physically handicapped to productive, independent roles in our society through passage of this legislation.

I am honored to submit the statements of Dr. Frederick T. Hill, medical director of Thayer Hospital, Waterville, Maine, and Dr. Harold N. Willard, director of rehabilitation at Thayer Hospital, for consideration by the subcommittee. I feel that the views of these doctors, who have had years of practical experience in dealing with the problems under discussion, should be given thoughtful consideration.

Health and the American Public Health Association are among the national bodies that have studied the opportunities, the responsibilities and the measures to be taken, along with the costs and the dividends.

Our Connecticut White House Conference Committee for Children, 1959, and our new White House Conference Commission on Aging are directing specific attention to these problems.

4. A few comments may be made, and questions raised concerning some of the bills which have come to attention.

On January 7, 1959, and on January 27, 1959, were introduced bills H.R. 1119 by Mr. Fogarty and H.R. 3465 by Mr. Elliott, respectively, both "To provide evaluation of rehabilitation potentials and rehabilitation services to handicapped individuals who as a result thereof can achieve such ability of independent living as to dispense with the need for expensive institutional care or who can dispense with or largely dispense with the need of an attendant at home to assist in the establishment of public and private nonprofit workshops and rehabilitation facilities and for other purposes."

The purposes are clear and indicate foresight in developing planning. In section 2(a) of H.R. 1119, an amendment is obviously related to Public Law 565, 83d Congress, chapter 655, 2d session, S. 2759, an act. Provisions for grants under section 202(g) title II seem to be clear. Under section 203, page 7, is a new State rehabilitation agency intended in lines 11 and 12? Improvement of conditions in existing agencies in a manner to provide for joint planning and cooperative action and adequate medical guidance will be important; and it is hoped that multiplication of State agencies will be avoided. The preparation of a "flow chart" and of methods for distribution of authority and funds in some localities will show the confusion and cumbersomeness of too many "cooks", often operating somewhat independently even though the intention is to benefit a handicapped person and a family. On page 12 of this bill, page 12, under definitions, and the same in H.R. 3465, what is meant by "therapeutic treatment"? Does this include medical advice, prescription, and supervision? On page 13 of these bills, line 2, will he "no longer require such institutional care", or that such care and attendance may be substantially reduced, or does this imply no care as referred to possibly on page 2, (b), line 10 and 11?

On page 15, (b)—in considering "but not be limited to * * *" reference may be made to paragraph (B) on page 15 as to relationships. Possibly this might state something such as: the following provided they are under medical direction, or supervision, with prescription. Among the ideas here is the question if there is enough reference to medical guidance.

Turning to the good House Joint Resolution 316, of Mr. Fogarty of March 19, 1959, paragraph 2 of page 1, does the term remediable in 80 percent of the cases refer to medically remediable or to other factors? In paragraph 3, is the definition of rehabilitation worker clear in this context? On page 2, should emphasis be given under reference to training that this can be done best in a medical setting, preferably in affiliation with a medical teaching institution? On page 3, reference to medical supervision is lacking. On page 4, is it practical in lines 6 and 7 to include a medical practitioner? When we see the value given by Dr. Krusen in the Office of Vocation Rehabilitation recently, we see great possibilities. On page 5, section 4, advisory committee, members "shall be chosen from" etc. This is good but is not in the Elliott bill—House Joint Resolution 494. Is a person in physical medicine desirable? In House Joint Resolution 494, is there sufficient provision for medical help and advice? (e.g. p. 4, lines 13-20.) On page 5, lines 11-17, no M.D.'s are mentioned.

5. ILLUSTRATIVE HISTORIES

(a) My attitude, both personal and professional, toward comprehensive rehabilitation was profoundly influenced by an intimate and impressive experience I had with a college student and his family. He lost the sight of one eye, had both hands blown off, and suffered other injuries in a laboratory explosion in 1938. The initial effect of this accident, in the midst of his professional education, was shattering to his morale and greatly handicapped him physically and in building a satisfactory career, but through sympathetic and highly skilled assistance that was fortunately available to him, he went on to complete a Ph. D. degree in chemistry and has become internationally known in the highly technical field of combustion, in its application to jet engines, rockets, etc. He drives his own car and travels extensively by himself, in the United States, Europe and

the Far East. He has achieved a happy home life, is the father of two boys who he joins frequently on skiing outings, and is active in his church and the social life of his community. The native intelligence and courage that this man possessed contributed greatly to this happy result, but it is very doubtful if these would have been nearly as effective without the understanding, encouragement and training received from rehabilitation personnel.

(b) Two case histories from the experience of a former Welfare Fund Medical Director, now a hospital director, will illustrate this further.

Case 1.—A 37-year-old woman became aware of increasing weakness and numbness in her legs and a few months later she was unable to walk. The diagnosis of a small hospital in another State was multiple sclerosis, with loss of sensation and use of legs. As many of you know, the cause of this disease is not known, but sporadic patches of scar tissue develop in the brain and/or spinal column, causing a variety of disorders.

The Welfare Fund referred her to a rehabilitation center, where a diagnosis of spinal cord tumor was made and a successful operation removed a benign tumor close enough to the spinal cord to have caused the symptoms.

She is now a healthy woman having avoided the life of a severely handicapped person because of this evaluation. The cost to the fund was \$1,000, but the cost to the community for her care would have been many times as much if she had not received a sound diagnosis and excellent management for an unexpected condition.

Case 2.—An 11-year-old girl developed slowly progressive weakness of her legs in July, 1945. In 1949 her situation was brought to the attention of the fund by her family physician. The diagnosis, muscular dystrophy—another disease of unknown causes—gave little hope to all concerned.

She was sent to a rehabilitation center in March 1949, where a deficiency disease that can be controlled by regular medication, was diagnosed. She was discharged within 2 months “very nearly a normal girl, as long as she continues to take regular doses of a medicine—prostimine. She finished her high school education, married in 1953 and has three healthy children. At a cost of less than \$3,000 and because of a thorough evaluation, she is living a normal life and avoiding the suffering and expense of disability.

(c) Prior to my becoming a member of the board of directors of Gaylord Farm Sanatorium, its services had been limited to the care and rehabilitation of persons afflicted with tuberculosis, for which it had an outstanding reputation over some 50 years, under the direction of a wise and skillful and understanding physician, Dr. David Lyman. Since this disease is being brought under control through improved treatment, Gaylord has had an opportunity to broaden its field to include rehabilitation services for persons having any remediable disability. I will now cite three case histories from our experience there, that I think will be helpful to the committee.

Case 1.—A 64-year-old man was admitted in December 1956 with his left leg amputated above the knee, diabetes in mild form and congestive heart failure due to an insufficient supply of blood to the heart muscles. A year prior to admission his wife had died, after prolonged suffering, from cancer. Since her death he lived alone, ate irregularly at various restaurants and never regained interest in living. His diabetes got out of control and possibly because of this, his left foot became so badly infected that his leg had to be amputated above the knee.

Following amputation, he was admitted to Gaylord in no mood for vocational rehabilitation or independent living. Readjustment to the point that a nursing home could handle his medical and social needs seemed about the best that could be expected.

This man was a patient from December 28, 1956, to June 28, 1957. He received daily medical supervision; rehabilitation nursing; frequent laboratory studies; physical, occupational, and work therapy; social service; vocational counseling and guidance; planned social activities; a therapeutic diet, and practical instructions about the preparation and selection of food.

As the treatment progressed, the patient began to develop higher goals for himself which he “sold” to the Gaylord staff and to the Connecticut Bureau of Vocational Rehabilitation.

Men in their 60's are often unable or unwilling to use artificial limbs, but we found in this man such a desire for self-sufficiency that an artificial leg was purchased for him by the Bureau of Vocational Rehabilitation. While the patient was not well coordinated, he was so well motivated that after several

weeks he could walk. Today, he is living alone in a small neat apartment, where he does all of his own housekeeping and cooking. The rest of his story is best told in his own words in the following letter which I received from him under date of June 9 of this year.

"DEAR DOCTOR: You will, I am sure, be glad to hear from one of your former patients, a patient who was brought under your charge on a stretcher, with very little expectation of ever being thankful for anything or anybody.

"Today I am glad to inform you I am employed in a business office, drive a car, have paid back to the State welfare the money they advanced for my hospital care, and am paying the bills accumulated during my wife's and my illness. All this I attribute to the treatment I received at your institution—the physical therapy, the medical care, the personal attention, and the followup after I left Gaylord. Again I want to thank you for what you did for me and are doing for others. Gratefully yours."

I would like to remark here that rehabilitation is not the most remunerative field open to the doctor of medicine and one engaged in it who does not get a big lift out of such a letter would do well to change to a field where the remuneration is paid entirely in money.

Case 2.—A 37-year-old woman with three children under 9 years of age was admitted to Gaylord on February 22, 1956. A college graduate, with a master's degree in music (piano), she had taught for several years. She was disabled by a devastating disease, lupus erythematosus, which had affected her nerves, joints, and internal organs, causing severe pain and paralysis of muscles. She could not move any muscles below her knees or lift her arms above shoulder level; her fingers were partially paralyzed.

At the time of her admission there was little hope of her return to her family in a useful capacity and no hope for her to again teach piano. The family situation was chaotic; her mother attempted to take care of her three small children. Her husband was unable to carry out his job to the best of his ability because of demands at home and concern for his wife.

For many months she had an "up and down" course; with her considerable courage and determination, thoughtful physician management, intensive nursing care, physical and occupational therapies, she was finally able to return to her home. Upon her discharge on March 25, 1957, after more than a year of hospital care she could walk with two short leg braces free of pain. She tires easily, with with scheduled rest she manages her home, her children, and is again teaching piano. Most important, she is home with her family, without need of daily medical care.

Case 3.—A 19-year-old boy was admitted June 20, 1956, with a 2-year history of Guillian-Barre syndrome—a disease affecting the body's nerves, which is marked by pain, tenderness, and weakness in the muscles supplied by the affected nerves. After staying 9 months at a medical center and 1½ years at a chronic disease hospital, he came to Gaylord so limited in his abilities that his only diversion was painting by holding the brush in his teeth. There had been no noticeable progress during these 27 months.

The goal was to teach him to live independently. Special devices were prescribed so he could increase his usefulness. Daily physical therapy also served to prevent contractures at the joints. His muscle strength gradually improved. Special devices became unnecessary. Our reevaluation gave us confidence to plan even beyond the goal of independent living—useful employment.

One year after admission he was discharged, completely independent. Using one cane, he attended his high school graduation. For the past year he has been employed by the Fuller Brush plant in his hometown.

This successful rehabilitation required the cooperation of 15 separate services, as well as the patient and his family.

General methods employed

The above specific cases are generally typical of the methods employed at Gaylord.

We feel that a large number of highly trained, highly skilled services are required for the best results. In addition to a full-time staff of doctors, nurses, therapists of various kinds, and social workers in the several categories of human need, we are fortunate in having a consulting staff of outstanding specialists from the New Haven area who visit Gaylord twice a week to consult with the full-time staff on special problems. With this staff, we feel we have the best advice available on almost any condition that may be encountered.

We also maintain close working arrangements with several medical centers, including the Grace-New Haven and Hartford Hospitals; all of Connecticut general hospitals; and all voluntary and special agencies offering related services. Following discharge from Gaylord, the services of family physicians, visiting nurse associations, and rehabilitation centers, such as those established in New Haven, Hartford, Stamford, and Meriden, are freely used and have proven most effective.

In addition to the above, we feel that it is very important that a patient's skills, his remaining abilities, or his potential abilities, should receive imaginative consideration and for this purpose a workshop equipped with a variety of machines and hand tools, is invaluable. Gaylord was fortunate in receiving a special grant from the Office of Vocational Rehabilitation in July 1958 for developing such a shop. This shop enables the staff to measure and develop work tolerance while exploring work skills, but most important is the effect on a patient's morale of finding himself able to do useful work. It banishes the enervating feeling of uselessness and dependency and gives him the courage to seek self-support.

Mr. GLAIMO. Dr. Robcliff V. Jones, Jr., associate in physical medicine and rehabilitation, University of Connecticut, will be our next witness.

H. Kenneth McCollam, executive secretary, Connecticut Board of Education for the Blind, and Guy Marchisio, chief, Children's Service, Connecticut Board of Education for the Blind.

**STATEMENT OF H. KENNETH MCCOLLAM, EXECUTIVE SECRETARY,
CONNECTICUT BOARD OF EDUCATION FOR THE BLIND, HARTFORD, CONN.**

Mr. MCCOLLAM. I am H. Kenneth McCollam, executive secretary of the Connecticut Board of Education for the Blind.

I am going to speak briefly from the braille outline that I have before me.

If I may, I request the permission of the committee to file a copy of what I am going to say and try to cover at a later date.

Mr. GLAIMO. Without objection, you may.

Mr. MCCOLLAM. I would like also to cover briefly the rehabilitation aspects of the discussions that we have before us and ask Mr. Marchisio to follow me with a summary of the matters pertaining to special education.

I want to open by expressing gratitude to the committee for the privilege of coming before you and also for the rare privilege that I think all of us had in sharing in the workshop study group that has been held in the previous 2 days in New Haven.

In connection with that, I think it gives those of us who at the agency level work with the blind a rare opportunity to meet with people of all interests in work for the blind, including, as Mr. Istas pointed out, people representing the Federation of the Blind and others with whom we sometimes have difficulty in sitting down with and sharing their thinking.

This has been a very worthwhile meeting and I think all of us have gotten a great deal out of it.

In connection with that, I wish to go on record here in favoring the report submitted by the workshop project by Mr. Greehan and we thoroughly endorse all of the proposals that were presented by him.

I would also like to go on record in favor of the bill for independent living as presented in 3465. We feel that that is a type of legislation

that is seriously needed in work for the blind in particular, although it has many great benefits to other types of handicaps than the blind.

We feel that the rehabilitation setting and the training that agency people have would be the proper place for the administration of the independent living provisions.

I would like further to recommend that the opportunity for training of personnel through grants, through traineeships, or through any of the many other avenues for obtaining specific training in the areas of the handicapped be encouraged and promoted in every way possible.

As many of you have already been told by other people who have presented their view here, there are a great many areas in which there is need for skilled professional workers working with the handicapped groups.

One particular group that I wish to mention particularly would be that of mobility trainer. We all know the difficulty that presents itself to any blind person in getting about. In recent years there has been developed a skilled mobility training and getting about by the use of cane or other recognized methods of guidance.

There has been no place in the country up to this point where a person may be trained in the skills which he could then later impart to blind clients.

If at all possible through the provisions of any of the bills before us we would urge that attention be given to this particular lack.

There has been a study made recently by the Office of Vocational Rehabilitation in conjunction with the American Foundation for the Blind in this area, and we hope from that will come some definite proposal.

Another point that I would like to emphasize again in the field of training, the need for a type of apprenticeship training that might be possible wherein a well trained, from an educational or academic point of view, a well trained individual, who may come out of one of the courses that Congress has made possible through the extension of the Vocational Rehabilitation Act, come out with a master's degree, but with no practical application of the theory that has been learned and learned well.

What I would suggest here is that Congress, through extension of the Vocational Rehabilitation Act, make possible grants which could be used for the financing internship or apprenticeship type of course in the States whereby these college graduates, oftentimes with a master's degree, can obtain a practical experience necessary to make them a worthwhile worker in the field of work for the blind.

The reason that the State cannot always do this or accomplish this very thing is because of the limitation of budgets, also the fact that there are serious restrictions on the matter of taking a person on your staff and then having to put him through a lengthy training period or internship.

I would also like to speak briefly on the broadening of the provisions of the Hill-Burton bill, which would encompass the establishment of rehabilitation centers, possibly not medically oriented or medically backed, but the type of center that would provide to blind people throughout the country the facilities that they are so rarely lacking in the field of prevocational and vocational training.

We have centers throughout the country for adjustment to blindness. The number of centers or places where we can expose blind clients to prevocational training or limited vocational training as well as the exposure to the various social needs of the individuals are lacking to a very high degree.

In the New England region some studies have been made by the Office of Vocational Rehabilitation with the thinking that perhaps a regional center might be established.

The numbers that have been indicated on the basis of this study are relatively small and it seems that it might not be feasible for a regional center for the blind alone.

I would welcome any thinking that might be possible in following out the recommendations of one of the previous speakers that a rehabilitation center on a regional basis for other types of handicap might also include the rehabilitation and training of blind individuals.

I would also like to endorse the recommendation made by Mr. Mungovan of Massachusetts at the hearing yesterday on the matter of the withdrawal of the need for applying the means test for readers for blind students.

That has presented a great deal of difficulty. We are allowed under the provisions of Public Law 565 to pay for tuition for a blind student without necessarily applying the means test. When we have to provide him with readers in order to obtain the education that he needs, we do have to make the application of the means test under the present provisions.

I would like very much to see that changed if at all possible.

In the interest of time I think perhaps now I will relinquish the balance of the time that has been allotted to me to Mr. Marchisio to deal with the special education.

Mr. GIAIMO. Thank you, Mr. McCollam.

May I say to you, Mr. Marchisio, in the interest of time will you summarize your statement as best you can and then leave your prepared statement with us.

(The statement referred to by Mr. McCollam follows:)

OUTLINE OF NEEDS OF BLIND PERSONS IN CONNECTICUT AND PROPOSAL FOR CHANGE IN EXISTING LEGISLATION

(By H. Kenneth McCollam, executive secretary, Board of Education of the Blind, Hartford, Conn.)

The board of education of the blind is an independent State agency charged with the responsibility of bringing multiservices to the blind of Connecticut. The register of known blind persons contains the names of some 3,700 individuals. The current budget of the agency calls for the expenditure of \$600,205 annually and of this amount \$327,200 is expended for education of blind children.

Representatives of this agency had the privilege of sharing in the 2-day workshop sponsored by the study committee established under the subcommittee of Congress and wished to go on record as endorsing the proposals submitted by Mr. Frederick D. Greehan, chairman of the section working with the visually handicapped.

The agency would further wish to be recorded as in favor of the passage of the independent living bill 3465 that is presently before Congress. It is the belief that the needs of blind persons could best be met by the administration of this new program through the well-established and professionally staffed personnel of the agency presently carrying out the provisions of the vocational rehabilitation program.

In order to meet some present gaps existing under the Vocational Rehabilitation Act of 1954 (Public Law 565), it is further recommended that Congress make available training grants to universities or colleges to establish training programs for mobility instructors for the blind. The need for mobility is probably one of the greatest in work for the blind that exists at the present time. Attempts through organizations such as the Hines Hospital of the Veterans' Administration and a few additional provide adjustment centers to meet this need; but the number of trainees that they are able to accept is so limited that years will be required to begin to meet the need in the several States. It is estimated that Connecticut might well use the services of two or more mobility instructors on a full-time basis, if properly trained personnel were available.

A secondary training project which seems highly desirable in the effort to obtain well qualified and trained personnel in the various areas of work for the blind, is the need to establish a training grant available to the several States that would provide the adequate compensation for an apprenticeship trainee for a period sufficiently lengthy to give him the much needed practical experience in the area of work for which he had been academically trained. Many persons are utilizing the training privileges under Public Law 565 to obtain master's degrees in vocational rehabilitation but have no opportunity to gain practical field experience that would enable them to be employed directly by a State agency. Most State agencies require at least 1 year of experience beside the college education.

It is suggested that the Hill-Burton law be amended to permit the use of the funds available under its provisions to be used for establishment of a rehabilitation center that would include prevocational and vocational training over and above the medical services which are presently required. It is suggested that studies be made to determine the need for such rehabilitation centers on a regional level and of a nature that would offer services to blind clients as well as to those of other handicaps.

It is recommended that a study be made of the application of the formula for allocating funds under Public Law 565 to reflect the need of certain States with a high per capita income who are receiving meager allocations of funds under section II of the allotment, which involves additional support funds available to the States as a whole. For example, in Connecticut, over the past 4 years when rehabilitation funds to the States in general have risen from \$23 million to \$53 million, this State has received only the following amounts of these funds:

1956-----	\$63, 045
1957-----	58, 322
1958-----	48, 885
1959-----	44, 899

It is recognized that the general application of the formula used in allotting funds to the states is generally acceptable to the country as a whole. It could be readily seen, however, that the great benefits derived by States with lower per capita income are being denied to Connecticut where despite the financial well-being of the State in general, there are limited funds available for vocational rehabilitation purposes. It is suggested that some thought be given to providing additional funds over and above the formula quota that could be made available on a State-matching basis of dollar for dollar.

This agency would also favor the removal of the requirement under the regulations of Public Law 565 of application of the means test to the provision of reader services to blind students. This regulation does not seem to be consistent with the payment of tuition fees without application of the means test, while at the same time the necessary reading service to permit a blind student to pursue his studies should be so stipulated.

It is further recommended that the provisions of the aid to the blind be modified so as to permit a larger amount of earned income to be exempt before an AB grant would be modified. The original provisions of the act stipulated that \$50 a month of earned income would be exempt. It is recommended that this exemption should be amended to read \$100 of income from any sources be exempt.

This agency wishes to express appreciation and gratitude to the committee for making it possible to appear and to participate in the workshop and hearings in connection with its study. It is further requested that this written report be made a part of the congressional record of the hearings.

**STATEMENT OF GUY MARCHISIO, CHIEF, CHILDREN'S SERVICES,
CONNECTICUT BOARD OF EDUCATION FOR THE BLIND**

Mr. MARCHISIO. Mr. Chairman, gentlemen of the committee, I would like to say initially that these points that I presented, these recommendations, although given to you from the point of view of Connecticut, I believe they apply pretty much to the whole country.

We have some eight points. We are asking that Federal help be given in the preschool area.

Very few of the States have sufficient funds particularly to help parents with the problem of blindness in children. Very few States, including Connecticut, have outright funds for this program.

We think this should become a definite part of the educational program. This is true of blind children as well as any other children where not only do you need help to assist the parents but a more formalized type of service is needed in terms of getting the children ready before school.

Two, the establishment, as has been mentioned here several times, of the regional diagnostic and treatment centers. The centers, particularly for multiple-handicapped children.

I would like to stress multiple-handicapped blind and also emphasize the emotionally disturbed ones. This is likely to be an area that is omitted in the states where the service is for physically handicapped, but not for the emotionally disturbed or people with emotional problems, with the additional handicap of blindness.

Three, again I think you have heard on this, the establishment and award of scholarships and graduate fellowships, not only on the university level. I am a little concerned about this, having taught at the university level myself, and this can become quite theoretical.

I think there should be two additions added to our scholarships, two phases:

One, that these also be given on a part-time basis as well as a full-time basis; that is, a person who is already working on the job, particularly in the teaching field where training is very expensive and salaries are not too high, and also in terms of practical knowledge.

Scholarships for training centers, for traveling to agencies and centers to see what is going on, this type of thing, as well as university training.

Four, I would like to read this one.

(A) Increase the Federal quota grant substantially above the \$30 per pupil basis with a formula that will not place the smaller States at a great disadvantage.

(B) Distribution of the Federal quota grant to additional and varied manufacturers of educational materials and equipment for all visually exceptional children.

(C) Provision for proportionate representation from both public school and residential school personnel (ex officio members of the board of trustees) in the administration, selection, manufacture, and distribution of materials and equipment from the American Printing House for the Blind.

Now, our fifth point is asking that statistics be included in the census.

I think you have heard from this one before, particularly in the light of the population, the age distribution and the job classification of all legally blind people.

Six, a redistribution of the regional libraries for the blind.

The State libraries where you actually have a reflection of the State needs.

A recognition that blindness is not total blindness alone, that these libraries should distribute large print materials to partially seeing people, particularly in the literature, the nontextbook line.

Seven, the serious dearth of large print textbooks and other literature, after decades of sporadic effort, remains one of our most urgent problems to be solved as far as the partially seeing child is concerned. Many people have tried to tackle this and do something about it, but very little has been done. If you find that the States cannot lick this problem, then perhaps this is the time for the Federal Government to step in.

There is nothing, very little in the literature, in the recreational reading line, of large print books. We are asking here that the Federal Government make a study and perhaps distribute this material from the American Printing House and through the Library of Congress or grants to States.

Finally, I would like to preface my remarks on this one because I have been a great booster for volunteers in the area of blind people, of helping to transcribe braille books and so forth.

In fact, I am on the board of trustees of the national organization and also very active on the executive board of the National Braille Club, so I would like to show appreciation of what the volunteers have done and there is a place for them.

However, my point is that the blind are almost the only group of handicaps that have to depend on volunteers in their formal education. Therefore, we say legally blind children are entitled to an education at least equivalent to the education they would have had if they could see sufficiently well to do their schoolwork in the usual way.

In this regard the Federal Government should seriously consider the possibility of paying for the materials ordinarily provided by volunteers, thus instituting a service adequately designed to meet the need, when needed, and without fostering the very charity that has followed the blind individual through the ages.

This may be done through direct grants to the States, through agreements with publishers, or through the Library of Congress or American Printing House for the Blind acting as a clearinghouse for subcontracting orders from the States.

Thank you very much.

Mr. GIAIMO. Thank you, Mr. Marchisio.

(The statement referred to follows:)

A STATEMENT CONCERNING EXPANDED SERVICES TO VISUALLY HANDICAPPED CHILDREN AND YOUTH BY THE FEDERAL GOVERNMENT

(By Guy J. Marchisio, chief of children's services, State Board of Education of the Blind, Hartford, Conn.)

There are a number of unmet and partially met needs to blind and partially seeing children and youth in which the Federal Government may help and in which the States are finding it difficult to provide services.

1. Recognize the preschool service to blind and partially seeing children as an adjunct to formal education by providing Federal matching grants to the States in a phase of the work lacking sufficient funds for stimulating early preparation for school. Such a service should include individual instruction and counseling to parents and children as well as nursery school training.

2. The establishment of regional diagnostic and treatment centers and the provision of such services within presently recognized facilities through Federal grants to the States for building and staffing facilities for minimal-cost service for multiple-handicapped children and blind and partially seeing children with additional handicaps, to include visually handicapped children with emotional problems.

3. Substantial scholarships and graduate fellowship aid for the personnel concerned with all phases of education of visually exceptional children on both a full- and part-time basis. Some Federal grants are available for this purpose on a full-time basis, but little or no funds are provided for staff development in a field where salaries are low and cost of training is high. Similar grants are now available to vocational rehabilitation staff in the several States under the Vocational Rehabilitation Act 4A1—special projects grant.

4. (a) Increase the Federal quota grant substantially above the \$30 per pupil basis with a formula that will not place the smaller States at a great disadvantage.

(b) Distribution of the Federal quota grant to additional and varied manufacturers of educational materials and equipment for all visually exceptional children.

(c) Provision for proportionate representation from both public school and residential school personnel (ex officio members of the board of trustees) in the administration, selection, manufacture, and distribution of materials and equipment from the American Printing House for the Blind.

5. Provision in the Federal census for accurate statistics on the population, age distribution, and job classification of all legally blind individuals in the United States and in the several States.

6. Redistribution of the regional libraries for the blind to State libraries for the blind that reflect State and community needs. A recognition that blindness is not total absence of sight through the distribution of large print books as well as braille and recorded literature by these libraries. A speedup in the number and variety of talking book records for children is urgently needed.

7. The serious dearth of large print textbooks and other literature, after decades of sporadic effort, remains one of our most urgent problems to be solved as far as the partially seeing child is concerned. It is highly recommended that the Federal Government, through quota grants, extend this service to both the legally blind and true partially seeing child and that extensive research be initiated for obtaining the exact title requested, nonbulky books, most appropriate size type, and multicolored photographs and pictures.

8. Legally blind children are entitled to an education at least equivalent to the education they would have had if they could see sufficiently well to do their schoolwork in the usual way. In this regard, the Federal Government should seriously consider the possibility of paying for the materials ordinarily provided by volunteers, thus instituting a service adequately designed to meet the need, when needed, and without fostering the very charity that has followed the blind individual through the ages. This may be done through direct grants to the States, through agreements with publishers, or through the Library of Congress or American Printing House for the Blind acting as a clearinghouse for subcontracting orders from the States.

Mr. ELLIOTT. Has Mr. Arthur L. DuBrow come in? If not, our next witness is Dr. Charles J. Klim.

Is Dr. Klim here?

Dr. KLIM. Yes.

Mr. ELLIOTT. Come around, Dr. Klim.

Dr. Klim, our time situation is such, with 40 witnesses today, that we will have to place a limitation of 10 minutes on your statement.

With that understanding, you may proceed, sir.

**STATEMENT OF CHARLES J. KLIM, ASSISTANT PROFESSOR, SPEECH
PATHOLOGY, EMERSON COLLEGE, BOSTON, MASS.**

Mr. KLIM. This will average seven, perhaps.

Emerson College in Boston was one of the first college units in the country to train students as speech teachers, speech pathologists, and audiologists.

It has its own speech and hearing clinic where students receive the training and supervised practice as a necessary part of their preparation for certification in the field of speech and hearing.

At the present time there are 135 children and adults seen weekly at this clinic. Lack of physical space and staff limit our services. We want to expand this facility for the public.

The college also provides part-time speech and hearing help for the industrial school for crippled children in Boston, Tufts University Cleft Palate Clinic, Sullivan Square Medical Center, Holy Ghost Hospital in Cambridge, Woburn Public Schools, and Boston Dispensary which serves the New England Medical Center as a whole.

These programs exhaust the time of our present staff. We are appealed to regularly to survey school systems for need in speech and hearing. We do what we can, but have to turn down appeals for help due to lack of staff and equipment.

Easter Seal Club, cerebral palsy groups, and medical clinics continually ask for speech and hearing service from us. We do not have the help to offer help in speech and hearing.

Even New Hampshire clinics call on us regularly for service. In order to keep up the high standard of training for our undergraduate students in speech and hearing and to keep our clinic adequately supervised, our graduate program in speech and hearing has been slow in advancing.

We are being pushed to offer more to graduate students who want to receive higher certification. We need and want to meet this demand.

We now lack the space and staff to expand. With additional funds we could provide immediately the staff and the equipment necessary for the people who will want advanced training.

Our college clinic has a waiting list for people who need speech and hearing therapy. Expansion of our graduate program would mean increased therapy service to the community. It would mean a place where more bachelor degree students could obtain advance training. It would mean also that many students of speech and hearing would stay in the Boston and New England area to obtain their training instead of leaving for outside of New England and there to study and eventually settle.

The theory is that if they study in New England, they may stay there. With the excellent training facilities connected with the college in regard to speech and hearing, the opportunities for research are excellent. We have not been able to study and to evaluate the many therapy techniques or ideas which may have clinical value; it may be because of our lack of funds to provide the staff.

We do have the cases. If we had adequate funds we could put to immediate use two more advanced certified people on our staff on speech. We could use another full-time person in hearing if we had funds.

Our facilities are now inadequate. We need soundproof rooms for hearing. We need to double our space in order to better serve our speech therapy clients.

We need to provide more in the way of parent education. We have been requested time and again to provide therapy for adult cerebral palsy groups and other adult groups.

We have been called upon to help guide the more rural areas of northern New England especially in regard to setting up programs to meet the speech and hearing needs of smaller communities.

These are critical needs. With money and staff we could do much more to provide initial guidance and survey then we are now able to do.

Two years ago Emerson College conducted a workshop in the speech and hearing needs of rural areas in New England. The gathering of people who attended to testify as to the specific needs in their communities revoiced what was generally known. They were unanimous in voicing a need for education of parents in the areas as regards speech and hearing and a critical need for diagnostic evaluation by qualified therapists and a drastic need for qualified therapists to provide regular therapy in the rural areas.

Today the need in these areas is just as great and just as critical as 2 years ago.

The colleges in New England need funds to provide the increased staff and to recruit students who could fill some of these needs upon graduation.

The students who graduate from our college have no difficulty gaining employment. The number of positions far exceeds the number of graduates who have been turned out annually.

This picture will continue in spite of increase in graduates.

My own introductory course in speech and hearing this semester has 62 students enrolled. These are potential therapists. This is our largest single class.

We hope this kind of increase will continue. Nearly half of these at this early point in training have voiced a desire to go into graduate training in speech and hearing. They are faced with a real problem of finance on the graduate level. The expense of undergraduate training alone today is all that most parents can afford. This is where most parents stop.

In order to go to graduate school the student must support himself. This is difficult. To encourage them we need fellowships, traineeships, and grants for some years to come to help them continue their studies. Federal grants would be most welcome. They are now and will be desperately needed in New England.

Thank you.

Mr. ELLIOTT. Thank you very much, Dr. Klim.

Are there any questions of Dr. Klim.

Thank you, Doctor.

Our next witness is Mr. L. P. Simons. Is Mr. Simons here?

Mr. Simons, I regret that it is necessary that we impose time limitation of 10 minutes.

Mr. SIMONS. That is all right. Most of the material I will present is in the document you have. I will abstract it.

Mr. ELLIOTT. Without objection, the complete statement of Dr. L. P. Simons will be made a part of the record, following his oral presentation.

You may proceed, Mr. Simons.

**STATEMENT OF L. P. SIMONS, EXECUTIVE DIRECTOR, EPILEPSY
INFORMATION CENTER, BOSTON, MASS.**

Mr. SIMONS. Thank you.

Of the 1,500,000 epileptics in the United States fully 80 percent have seizures eliminated or reduced to a minimum. Translated in terms of employment this means that 80 percent properly can be employed in competitive industry.

Unfortunately, being able to work does not mean the epileptic can find a job. There are many industries that will not hire an epileptic even if completely controlled, let alone employ him if attacks occur as frequently as once a year.

The employers offer the following reasons as to why they cannot hire an epileptic:

One, that he has a high enough accident rate.

Two, that his workman's compensation rates automatically rise when an epileptic is employed.

Three, epileptics have a high absentee rate.

Experience has demonstrated, both through research and on-the-job experience, that this just is not true.

For example, in 1958, the Ford Motor Co. in Dearborn, Mich., reported not one accident out of 165 workers with epilepsy.

In 1951, the U.S. Department of Labor study demonstrated there is no significant difference between the disabling and nondisabling accident rate of epileptic and nonimpaired workers.

The workman's compensation board in New York found that the average number of closed cases involving epileptics was only 10 out of 100,000.

It would not seem that people with epilepsy are particularly accident prone.

As far as workman's compensation rates, rates are based on experience rather than whether handicapped people are employed?

It was found also in 1951, the U.S. Department of Labor study, that epileptics actually lost less time because of accident than the nonimpaired worker.

The problem of the epileptic in industry seems to be primarily that of education. We know that the epileptic can work. They find it difficult to get a job.

I would like to propose a three-point program that the Federal Government do undertake to show leadership in getting epileptics back to work.

The first point is education. Since our attitude bars the epileptic from employment I recommend that the Federal Government provide funds for an epileptic education program and program developed in the following manner:

One, that the Secretary of Health, Education, and Welfare call an epileptic-in-industry conference by industrial leaders, that this conference be expanded to the State level and that this Government pro-

vide funds through the State offices of rehabilitation for the education of business leaders regarding the employability of epileptics.

Two, Workman's Compensation

Three, improving vocational rehabilitation techniques. Most people with epilepsy who require rehabilitation and placement are referred to their local office of vocational rehabilitation.

Thank you very much.

Mr. Elliott. Thank you, Mr. Simons.

(The formal statement of Mr. Simons follows:)

STATEMENT OF L. P. SIMONS, EXECUTIVE DIRECTOR, EPILEPSY CENTER, BOSTON, MASS.

Yesterday this committee heard Mrs. Albert Grass, president of the American Epilepsy Federation, discuss the problems of the epileptic child in school.

Today, I would like to discuss the epileptic in relation to employment.

Of the 1½ million epileptics in the United States, fully 80 percent can have their seizures eliminated or reduced to a minimum. Translated into terms of employment, this means that 80 percent, or over 1 million epileptics, properly placed, can be employed in competitive industry.

This is not to imply that a great many of the 15-percent group of epileptics who are not so well controlled cannot work, but, rather, that the 80 percent segment should present no problem to industry at all.

Unfortunately, being able to work does not mean that the epileptic can find a job. There are many industries that will not hire an epileptic even if he is completely controlled, let alone employ him if his attacks occur as infrequently as once or twice a year.

Loyalty to tried and trusted employees goes out the window when epilepsy is involved.

For example, we have the case of a man who was employed by a large insurance company for 7 years and was summarily fired when the company learned that he had had a seizure at home. The seizure resulted simply because the fellow had run out of medication.

Why does industry object to employing the epileptic? Employers offer the following reasons as to why they cannot hire epileptics:

1. The epileptic has a high industrial accident rate.
2. Workmen's compensation rates automatically rise when an epileptic is employed.
3. Epileptics have a high absentee rate.
4. Epileptics can perform very few jobs.
5. Other employees object to working with an epileptic.

Let us look at these objections and see how they stand up in the light of documented data.

Do epileptics have more industrial accidents than the nonimpaired worker?

As of 1958, according to the safety director of the Ford Motor Co. plant in Dearborn, Mich., there was not one accident worth noting, out of 165 workers, with epilepsy. Of course, seizures occurred, but they did not result in accidents.

A study by the U.S. Department of Labor in 1951 demonstrated that there is no significant difference between the disabling and nondisabling accident rate of epileptics and nonimpaired workers.

The Workmen's Compensation Board of the State of New York found that in the 8-year period, 1945-52, the average number of closed cases involving epileptics was only 10 out of 100,000.

In view of these facts it is evident that the epileptic worker is not an industrial accident risk. The attitude that he is, as held by industry, is completely without foundation.

Do workman's compensation rates automatically rise when an epileptic is hired?

In 1954, the Association of Casualty & Surety Cos. issued the following statement as regards workmen's compensation rates:

"Insurance rates are based on accidents involved in operation and the company's accident experience. No consideration is given whatsoever to the question of whether or not handicapped workers are employed."

Here again we can see that misinformation is hurting the epileptic in his search for employment.

Do epileptics have a higher absentee rate than the nonimpaired worker.

The 1951 U.S. Department of Labor study uncovered the interesting fact that the epileptic actually loses less time because of accidents than does the nonimpaired worker.

Further, the study showed that the work attendance records of epileptics were the same as for those on the nonimpaired worker.

Again, we have another meaningless argument.

Are epileptics limited as to the jobs that they can perform?

According to the pamphlet, "Patterns of Disease," published by Parke, Davis & Co. in 1958, epileptics were holding jobs in the following areas:

"Professional, business, and college students, 27 percent; clerical and skilled workers, 28 percent; sales and service workers, 20 percent; unskilled laborers, 25 percent."

From these statistics it can be seen that epileptics can handle jobs in every field of endeavor.

Do people object to working in close proximity to an epileptic?

Unfortunately, in some instances this is true, but it is not irrevocable. The Epilepsy Information Center has found that this problem can be solved when an employer will take time to interpret epilepsy to his employees.

The facts that I have just presented show conclusively that there is no valid reason why an epileptic who is completely or relatively free of attacks cannot be placed in competitive industry.

Further, the data indicates that the underlying reason the epileptic has difficulty with employment is not due to his physical condition, but, rather, due to the erroneous attitudes of industry toward him.

We cannot afford to allow these attitudes to continue indefinitely. Such attitudes are degrading and rob people with epilepsy of their dignity, they are causing a pool of potentially productive workers to be untapped.

From an economic point of view it is costing the taxpayers of this country a lot of money to support a group of people who are not working because of facts that were valid 100 years ago.

Since returning the epileptic to gainful employment is a national problem, I believe the Federal Government should become more active in this area. I would like to propose a three-point program which, if adopted by the Federal Government, would lead the way to acceptance of the epileptic by industry:

1. Education

Since outdated attitudes are barring the epileptic from employment, I would recommend that the Federal Government provide funds for an epileptic-in-industry educational program, and that the program be developed in the following manner:

A. That the Secretary of Health, Education, and Welfare call an epileptic-in-industry conference composed of industrial leaders throughout the Nation.

B. That this conference be expanded to the State level.

C. That the Federal Government provide funds through the State offices of vocational rehabilitation for the education of business leaders as regards the employability of epileptics.

2. Improving vocational rehabilitation techniques

Most people with epilepsy who require rehabilitation and placement are referred to their local office of vocational rehabilitation.

Unfortunately, because these units have large caseloads, and because of the difficulties in placement the epileptic is often overlooked or written off as not being suitable for rehabilitation.

To remedy this situation, I would recommend that the offices of vocational rehabilitation located in large urban centers establish within their organizations a division of epileptic services for a 5-year period. This special service devoted solely to epileptics would have its own counselor, social worker, and placement officer.

By establishing a division of epileptic services, I believe the following would be accomplished:

1. Rehabilitation services would be available to a more diversified group of epileptics.

2. A fund of knowledge about the employability of epileptics would be built up.

3. A concentrated effort to breaddown employer resistance to the epileptic would result.

4. Realistic standards for the employability of epileptics would be established.

Although there is a certain amount of resistance to establishing special services for special groups, I believe that the problems of the epileptic are so complicated that at least for a trial period of 5 years a program offering the epileptic specialized employment services is required.

3. *Prevocational counseling*

If the handicapped child is to develop into an economically productive adult he must have expert prevocational counseling by people who are familiar with the requirements of industry in this regard.

Also, the handicapped child must have counseling very early in his academic career.

I would, therefore, recommend that the Federal Government make additional funds available through the local offices of vocational rehabilitation for prevocational counseling of handicapped children and that this counseling be offered at the junior high school level.

In closing, I would like to say that money spent by the Federal Government in returning people to work comes back to the Government in the form of increased tax revenues.

I can think of no better source of new tax money than the 6 million handicapped people in America.

Mr. ELLIOTT. Our next witness is Mr. Oscar K. Weiner.

Is Mr. Weiner here.

Our next witness is Miss Frances Tappan.

Is Miss Tappan here.

Miss Tappan is the technical director of the School of Physical Therapy at the University of Connecticut.

STATEMENT OF FRANCES TAPPAN, TECHNICAL DIRECTOR, SCHOOL OF PHYSICAL THERAPY, UNIVERSITY OF CONNECTICUT

Miss TAPPAN. In the interest of gaining your complete attention, I have made my statement very short.

The Connecticut Chapter of the American Physical Therapy Association has asked me to speak to you concerning the educational aspects and in particular connection with the bill H.R. 3465 which is concerned with the most expedient rehabilitation of handicapped individuals.

Obviously, this care depends directly on the number and quality of therapists who can be educated to assume the immediate responsibility for this rehabilitation.

It is my particular responsibility as an educator to see that this education leads ultimately to the best possible method of physical rehabilitation.

Numbers at this point do not concern me as much as the quality of the therapists which we can graduate in our various schools. This quality depends directly upon the contemporary tools which are available for teaching purposes.

I am particularly concerned to find that, according to rehabilitation and training memo No. 60-5E, Department of Health, Education, and Welfare, under priorities for support places the specific project for development of teaching materials as its fourth priority.

The value of the three priorities which precede this cannot be denied for while it is indeed important to expand existing curriculums, encourage graduate study, and encourage specifically graduate education in physical therapy, it is even more important as I see it, to provide up-to-date, clear, and concise visual aids such as motion pictures, slides, charts, models, and printed materials to assure the fact that the therapists we do graduate are all well prepared to render the best patient care possible.

Other organizations and associations are doing a magnificent job with scholarships for these students, but there is also almost no other source other than the Office of Vocational Rehabilitation that will give us needed help to provide teaching materials.

I have made this point briefly and I hope strongly.

Anything you can do to strengthen this aspect of the program would, I am sure, contribute to physical therapy education throughout the country.

Thank you very much.

Mr. ELLIOTT. Thank you very much, Miss Tappan, for your testimony.

You have made a good point and have made it well.

Miss TAPPAN. Thank you.

Mr. ELLIOTT. Are there any questions.

Thank you, Miss Tappan.

Miss TAPPAN. Thank you Mr. Chairman.

Mr. ELLIOTT. Is Mr. Arthur L. DuBrow here?

Is Dr. Robcliff V. Jones here?

Mr. JONES. Yes, sir.

Mr. ELLIOTT. Mr. Jones is an associate in physical medicine and rehabilitation, assistant professor of medicine of Yale University.

We regret that we must impose a 10-minute limitation on you.

STATEMENT OF ROBCLIFF V. JONES, ASSOCIATE IN PHYSICAL MEDICINE AND REHABILITATION, ASSISTANT PROFESSOR OF MEDICINE, YALE UNIVERSITY

Dr. JONES. Rather than go over every point of the prepared statement I have, I would just like to bring out some major points.

Mr. ELLIOTT. After Dr. Jones has summarized her report, then the report will be made a part of the record, without objection.

Dr. JONES. First of all, I would like to express the appreciation of myself and all of us who are testifying here today and who were at the workshop in the last 2 days.

In regard to the needs for the New England area in rehabilitation, in special education, I think this will come out adequately from the workshop report that you will hear.

Inasmuch as we are concerned with individuals who have physical and mental handicaps and physical and mental impairments, we are concerned with individuals having specific medical problems.

Because of this, we are working with patients; and I think it is very important that we have adequate mental direction, supervision, and guidance in the planning of such legislation and in the implementation of this.

Now, as to where the facilities would be set up, or increased, I think this should be in no way limited to any particular group or place. But I do think that where it is possible we should use facilities having to do with medical schools.

The reason for this is that it would enable us to draw on a pool for future workers in the field, from young medical doctors and allied workers in the coprofessions that work in the medical centers, but I would like to repeat that this in no way means I feel this should be limited to any area like this, but it should be given consideration.

In regard to the independent living bills, 1119 and 3465, I think the goals of these are admirable and I am in entire accord with them.

One of the things that concerns me—and this in no way is a criticism of the bill; it is something that I think we should try to keep in mind when it comes to implement this—is that at present one of the major tests of successful rehabilitation is how many of the individuals that are working on this program are placed in a job.

Now, this extends the area of individuals being helped to a much larger group. I am apprehensive lest, say, the vocational counselor, who now has a larger number of patients to work with and individuals to work with, may not apply himself as vigorously toward the ones that are potentially employable.

I am merely transferring on to the vocational counselor what I have to do when I have a lot of work to do.

I try to cover it all and it is very difficult to make this final step, getting a job for the patient.

Mr. DANIELS. What do you recommend in this case?

Dr. JONES. All I can say is that this should be kept in consideration in every vocational counsellor's mind when he is working with them if it turns out the vocational counsellor will be the one utilized in carrying out this purpose.

Mr. DANIELS. Do you approve the idea of independent living under that bill?

Dr. JONES. I am sorry?

Mr. DANIELS. I say, do you approve the principle of developing the idea of independent living?

Dr. JONES. I certainly do. I am all for it.

But I think we should be careful not to fall into the pitfall that I can see occurring which I have just described.

In regard to specific points in the bills, I am a little apprehensive about having this all under one agency. I think this probably is necessary to make sure that we have an efficient program, but I am apprehensive that some of the very good groups that have a lot to offer might not be utilized as adequately as if this were dispersed through numerous areas.

I do not know the answer to this administrative problem.

Another point that concerns me some, and I must admit that I do not understand the wording on these particular parts adequately, is that in giving out the funds, say four times a year, if it comes out to be this, or twice a year, if there is some way that we could avoid the situation where, say, in June money may run out and patients have to wait until December before they can be taken on a program and then in December there is a lot of money, relatively a lot of money available, and suddenly everyone is looking for patients to utilize this.

I don't know whether this is a reflection of planning for future funds for the following year, or not.

I do not know how to overcome this, but I think it is something that should be taken into consideration so that we have a continuing amount of money without feast and famine, so to speak.

Those are the main points I would like to make, sir.

Mr. ELLIOTT. Thank you very much, Dr. Jones.

Did Mr. DuBrow come in?

Mr. DuBrow. Yes, sir.

Mr. ELLIOTT. Will you come around, please, Mr. DuBrow.

Mr. DuBrow is present of the Connecticut Rehabilitation Association.

I am sorry to say to you, Mr. DuBrow, we have to impose a limitation of 10 minutes.

Mr. DuBrow. I don't think I will take that long, sir.

Mr. ELLIOTT. You may proceed.

STATEMENT OF ARTHUR L. DuBROW, PRESIDENT, CONNECTICUT REHABILITATION ASSOCIATION

Mr. DuBrow. I would like to apologize for being late. I was informed by some people who participated yesterday that there was no need for me to rush since you were running pretty late yesterday. I took that as gospel.

Mr. ELLIOTT. We have speeded up a bit today.

Mr. DuBrow. The Connecticut Rehabilitation Association which I represent has a membership of well over 300 people in the State of Connecticut comprising both professional workers in the field of health, education, and welfare, and also numerous private citizens from all walks of life who are interested in and concerned with the problems of the handicapped.

The association has three points which we would like to present our viewpoints on.

The first of these is that we are a chapter in NRA as you well know, and we would like to go on record as definitely endorsing in principle the proposed legislation for independent living services.

However, the Connecticut association is concerned with some of the restrictive elements of the legislation in terms of proposing to make these services available to only two categories of handicapped people, those in institutions and those who are able to afford the luxury of an attendant.

From figures which we have been able to compile from the Connecticut State Department of Welfare, the Connecticut Bureau of Vocational Rehabilitation, and the Connecticut Society for Crippled Children and Adults, it looks as though there are something between 8,000 and 10,000 people in the State who are seriously disabled, who could profit from this kind of service, but who do not fall into these two categories of being in an institution or having an attendant.

Now, this number, of course, is being added to daily in terms of accident toll and illness and so on.

So this becomes a significant number of people for whom rehabilitation services on the State or Federal level are not available.

We are concerned about the possibility of providing some sort of service for this group of people.

The second point has to do with the acknowledged shortage of rehabilitation facilities. I think it is pretty well documented that nationwide there does exist a shortage of rehabilitation facilities.

However, the association feels it should be recognized that this situation does not pertain in all parts of the country and there are areas in the country where there are adequate rehabilitation facilities.

It should be noted that these rehabilitation facilities in many cases are not being utilized to their fullest maximum. The proposed legislation holds out the hope that Federal money will be available for building new facilities and for adding to existing facilities, and it is the association's hope that if the legislation is approved, in whatever form it may be, and that Federal money does become available that somebody take a good, long, hard look at the area where the money is going in terms of what the rehabilitation facilities are there and how much use is being made of these facilities before new Federal money is made available for construction of additional facilities.

I think this was our second concern.

The third point that we wanted to make concerned also the shortage, this time in the area of trained personnel. We feel that a good start has been made toward meeting the needs of shortages in terms of rehabilitation counsellors through the present programs in the various colleges and universities.

However, more and more of the other disciplines are becoming involved in the work of rehabilitation and it would be the association's hope that some provision be made for encouragement, scholarships, training for allied disciplines in terms of medical social workers, psychiatric social workers, psychologists, and other professionals who might be encouraged to enter into the field of rehabilitation and whose services are very badly needed and who are in very short supply.

These are the three major points which the association wanted to present and on behalf of the association I would like to thank the committee for the opportunity of presenting these viewpoints.

Thank your very much.

Mr. Elliott. Thank you, Mr. DuBrow.

Without objection, the the witness' statement will be made a part of the record immediately following the gentleman's oral statement.

Mr. DuBrow. Thank you.

(The statement referred to follows:)

STATEMENT SUBMITTED BY ARTHUR L. DUBROW, PRESIDENT, CONNECTICUT REHABILITATION ASSOCIATION

The Connecticut Rehabilitation Association, which I represent, comprises a membership of more than 300 people in the State of Connecticut. These members are both professional workers in the fields of health, education, and welfare, and also private citizens from all walks of life who are interested and concerned with the problems of the handicapped.

The Connecticut Rehabilitation Association would like to go on record as heartily endorsing the proposed legislation to provide independent living services. However, the association is concerned with the restrictive elements of this legislation which proposes to make these services available only to those individuals in institutions or to those who have an attendant present. From figures compiled from the State dept. of welfare, the State bureau of rehabilitation, and the Connecticut Society for Crippled Children and Adults, it would

appear that there are between 8,000 and 10,000 disabled persons in this State who do not fall into either of these two categories. These disabled individuals who are not in institutions and who do not have an attendant are just as much in need of independent living services as the two groups specified in the proposed legislation. The daily toll of accidents and disease is constantly adding large numbers to this latter group.

It has been well documented, that nationwide, there is a shortage of rehabilitation facilities. However, the association feels that it should be recognized, that in many parts of the country, adequate rehabilitation facilities do exist. It should be likewise recognized that many of these existing facilities are not being utilized to their fullest capacity. Therefore, the association would like to recommend that, before Federal funds are made available to any area for the addition of or the construction of new rehabilitation facilities, steps be taken to insure the fullest use of existing facilities and a request for Federal funds intended for new facilities be fully justified and substantiated.

The Connecticut Rehabilitation Association is also concerned with shortages in the area of trained personnel. It is felt that excellent progress is being made in terms of meeting the needs where rehabilitation counselors are concerned. However, it is now evident that other disciplines are becoming more involved in the process of rehabilitation and the association feels that some provisions should be made for assistance to prospective medical social workers, psychiatric social workers, psychologists, and other professional workers who are willing and anxious to devote their efforts in the field of rehabilitation.

On behalf of the association, I would like to thank the committee for the opportunity of presenting the viewpoints of the organization.

Mr. ELLIOTT. Has Mr. Oscar Weiner come in yet?

I notice that Mr. Stanley Myers is here. He is scheduled to testify in behalf of the Parents and Friends of the Mentally Retarded Children of Bridgeport, Conn.

Mr. Myers, will you come around and give us the benefit of your testimony?

We are very happy to have you, sir.

STATEMENT OF STANLEY MYERS, ON BEHALF OF PARENTS AND FRIENDS OF MENTALLY RETARDED CHILDREN, BRIDGEPORT, CONN.

Mr. MYERS. It is a pleasure to be here, sir.

Honorable Chairman, ladies and gentlemen, members of the committee, in 1956 a station wagon stopped at the house of a 24-year-old girl. There is nothing different about this normally; this happens every day in our lives where handsome young men stop at 24-year-old girls' homes and take them out dancing, dining, and to the movies.

Unfortunately, in this case we have a little different situation. This 24-year-old girl was being taken out for the first time in her life by another man. She had never been out of the house before in the company of anyone else other than her mother or her father, or probably both.

She could not walk. She could not talk. She could not go to the bathroom by herself. She could not feed herself.

But for the first time in her life she was leaving a home to go to "school."

I must put the school in quotes. This girl was picked up by a driver and carried to a station wagon and placed in that station wagon and taken to a center in Bridgeport and cared for there for a period of a short 3½ hours.

For the first time in 24 years this girl smiled at someone else. For the first time in the family's life they had an opportunity to go out together without worrying whether the child was adequately cared for. I cannot measure this in terms of money or in terms of material benefits to anyone. I can only measure it in terms of what it means to a family to have hope and something for a child who is presently remaining at home.

Now, granted you can say, "Why should not this adult be placed in an institution?"

We don't have the right to make that decision. This remains with the parent to make this decision. But at the same time, even if this 24-year-old girl was to be institutionalized in our State alone because she is mentally retarded, there would be a 3- to 5-year waiting period.

During that period must we deny this individual an opportunity to progress?

When I am asked why you keep bringing this child in, why don't you force these parents into institutionalizing this child, I can only give one answer: "She smiles," and for this reason every penny that is spent on this child is worth it.

The same thing applies to a 7-year-old or a 9-year-old who is inadmissible to public school training because they are mentally retarded. There is a bill presently before the Congress and I probably am getting off the point here, but a parent in Norwalk comes to me and says, "I came to this country from Hungary, out of Austria. All my family was admitted to this country except my 13-year-old mongoloid boy who cannot come because he is mentally retarded."

This has been the history of the problem of the retarded for practically forever. The problem now faces us, I think, and we as society must face this problem and examine our own conscience.

Toward this end the Parents and Friends of Mentally Retarded Children of Bridgeport, a parent-sponsored organization, has endeavored to create services for the retarded children and adults in the community, where the problem, we feel, must be met in the eventual final analysis.

Toward this end we feel that the Federal Government can stimulate the local organizations, the State organizations, who can benefit these individuals, can stimulate them in helping to meet the needs of these individuals. To this end we feel that a number of things could be done.

No. 1, we feel that there is to our knowledge no specialist in the field of mental retardation on a national level. The Office of Vocational Rehabilitation, which takes a great interest in this problem, does not have anyone specifically delegated to the problem of the retarded.

The States do not have anyone specifically delegated to the problem of the retarded. Direct grants to workshops have been provided. We feel they should be extended on teaching grants which should be granted for purposes of providing services we feel are needed of the specialists in vocational placement for retarded should be provided.

In the Office of Vocational Rehabilitation in the U.S. Employment Service areas; added services in vocational rehabilitation in State training schools should be provided.

Through the Federal Government we feel that the vocational educational of the retarded should be investigated and expanded in the direct grants to State trade schools.

School work programs are being investigated now where adults go to school for a 3-hour period and work for a 3-hour period. These should be further investigated.

Grants for subtrainable adults in sheltered workshops: We know what they cannot do generally. We are not so sure as to what they can do. This, we feel we must find out.

In the area of special education, preparation of teachers for subtrainable children, children who have been diagnosed as mentally retarded by one individual or perhaps by other individuals, and perhaps there is a misdiagnosis—perhaps we should look into this more closely so that the subtrainable, as he is so classified, is not stigmatized for the rest of his life as a subtrainer without opportunity to improve the capacity that he presently has.

Research into some more effective teaching of teachers; speech training for retarded: At present it is most difficult to get speech education for mentally retarded children presently participating in public school programs.

Grants for competent clinical psychologist and social workers in public school systems, with medical consultants available all for the purpose of differential diagnosis.

The possibility of reimbursement grants for recreational programs for school-age children. Staff personnel in the Federal Government in education for correlation and standardization of days and curriculum for training.

Grants to personnel in State offices of education to work more closely with local boards of education.

There are many problems that exist in this field and many areas which we can investigate for purposes of benefitting a tremendous segment of the population which formerly has had little concern expressed over the needs and the desires of these individuals.

I appreciate being here. Thank you for the opportunity.

Mr. ELLIOTT. Thank you, Mr. Myers.

Mr. GIAIMO. Mr. Myers, is part of this difficulty in the field of mental retardation in our State the fact that we have waiting lists in our training schools and so forth, the fact that there is not a sufficient amount of public awareness or concern?

Mr. MYERS. As you probably know, the last Legislature of the State of Connecticut has recognized the problem and passed a series of bills which we trust will make the public more aware of the problem, as well as provide services to the retarded, and we feel on a community level. Although there is a waiting list of 3 to 5 years in the State training schools, I am of the personal opinion would never be able to build the State schools to house the potential number.

As an example, last year the number of live births in the Greater New Haven area—Bridgeport, Derby, Milford—there were 15,000 live births. If we estimate conservatively 1 percent of the population being mentally retarded, that gives you an indication of just the number we must care for as of last year. Compounding that with this year's births, this gives you an idea of the potential we must recognize.

Mr. GIAIMO. The difficulty I see in this whole field of mental retardation is that there seems to be a shortage of facilities, funds, and training personnel; is that not true?

Mr. MYERS. Yes.

Mr. GIAIMO. Is that not the reason for this primarily, the fact that until there is sufficient public recognition of this problem so that then the States and local governments and perhaps the Federal Government will become aware of it, until such time it is very questionable whether we are going to get the trained personnel and facilities?

Mr. MYERS. This is true, but we feel there is another problem involved, too. We must not only get the public aware of the problem, we must get the parent aware of the problem, the professional aware of the problem.

We have heard for a number of years that we do not have sufficient teachers in the field of mental retardation. We also do not have sufficient classes in the field of mental retardation.

This is a vicious circle which will never end. If you don't have the classroom you will never find the teacher. If you don't have the teacher you will never get the classroom.

It is true, we need a great deal more public awareness of the problem. At the same time, unless the start is made, we can never make the public aware of what the need is.

If I may extend this just one moment, I personally feel that if we are in a position to start small, which has happened in the State of Connecticut, we then can build from that point. But if we are not in a position to start at all, it is a question as to whether we will ever start.

Mr. GIAIMO. One of the questions that will be thrown at this committee in Congress at such time any recommendation will be made to furnish assistance to mental retardation, one of the first questions will be thrown at us as to why do not the States do more about it? What is the answer to that?

Mr. MYERS. Let me put it this way: I will put it on a local level.

You gentlemen were kind enough to visit a center yesterday that started on a local level without one penny's aid from the Federal Government, or from the State government. It was all done through community awareness of the problem, community support of the problem.

If we can present the problem to the community in such a way as to inform them of the need, if we can eventually find a number of children whom we suspect are mentally retarded, the State of Connecticut conducted an investigation in 1957 where they estimate that there are approximately 40,000 known mentally retarded children and adults in the State of Connecticut alone. It is projected to about 2 percent of the population.

These are known figures. So the problem has to be brought out into the open, No. 1.

No. 2, once it is brought out in the open, if we don't meet it at that level, then we are back to where we started from.

Mr. GIAIMO. Thank you.

Mr. DANIELS. Mr. Myers, what do you estimate the mentally retarded population of the United States to be?

Mr. MYERS. The national statistics claim 3 percent of the population is mentally retarded. Our own feeling is that if this is true,

roughly 2 percent of the population is retarded, who will need some assistance in supervision as far as living in a community is concerned.

One percent is that borderline level that perhaps we will never get to see. They get jobs and adjust to the community and move in the regular society.

Mr. DANIELS. As I have been listening to the witnesses that have been testifying here, we have a pretty sick Nation, 10 million disabled housewives, 8 million speech and hearing defectives, 1½ million epileptics.

You just gave me a figure of 5 million mentally retarded. This is only part of the field.

Mr. MYERS. It is a matter of degree, if I may say so, Congressman. No. 1, the individuals about whom you are speaking are individuals who perhaps can be cured or who perhaps can subsist on a normal level.

We are talking about a segment of the population who will never be cured. We have so little research in the area to find the reasons. Presently today we know approximately 77 different reasons for mental retardation. I can quote you four which have been investigated recently that we think we can control.

We don't know yet, because it is so recent we don't have enough proof to say it can be controlled.

So the area of research has to be looked into more fully.

Mr. DANIELS. With such an alarming number of people who are ailing in one manner or form or another, do you think there would be a greater awareness of the problem nationally and that something would have been done about it prior to this date—

Mr. MYERS. I would think so, but I have never been able to figure out why it has not happened.

Mr. DANIELS. Fortunately, our committee under the chairmanship of Mr. Elliott, is endeavoring to do something about it.

Mr. MYERS. Thank you.

Mr. ELLIOTT. Thank you very much, Mr. Myers.

Now, has Mr. Weiner arrived yet?

Mr. Weiner, we have restricted our witness today to 10 minutes. If you have a longer statement than that and you want to summarize it, I am happy to say to you that the complete statement will be made a part of the record.

You may proceed, in view of that limitation, in any manner you care to.

**STATEMENT OF OSCAR D. WEINER, EXECUTIVE DIRECTOR,
CHILDREN'S CENTER, HAMDEN, CONN.**

Mr. WEINER. I am representing here the Children's Center which is a private association located in Hamden.

I would like to speak from the point of view of opportunities through the rehabilitation acts that might be considered by the Federal Congress to augment the treatment and study of emotionally disturbed children who are residents at our institutions.

These children have not been able to meet the demands of living as a member of the family. We feel that at our agency we have the ability and the potential to structure treatment and to give appro-

priate services to these children except in the area of schooling which has become increasingly difficult.

There are now 72 children in residence. Some of these may benefit by keeping their ties with the community, by attending public schools in New Haven.

However, it has been found by both the school faculty and by our staff that many of these children need special classroom services, preferably located at the institution where they can be more individually supervised by our teachers in small groups.

The incidence of school maladjustment as a major reason for referrals to our institution is increasing at an alarming rate.

Whereas 2 years ago about one-third of our referrals were children who had repeated major difficulties in public schools, now almost three-quarters of our referrals emphasize this.

These children come to us after moving from one temporary home to another and from school to school, having had little opportunity to develop trusting relationships, confidence, incentive or skills so that they might achieve some learning.

Out of our 72 children we have 18 in 2 special classrooms at our institution. Both we and the very cooperative local public school people feel that this simple environment for a temporary period is absolutely necessary during the treatment of these children before they go into the more complex public school system and especially in the secondary schools where they must go from classroom to classroom, from teacher to teacher, without the benefit of constant and consistent supervision.

There are, in addition, 16 of our children who at this moment desperately need special classroom help.

We and the public school authorities feel it is a pity that these children and many on our waiting list, cannot be provided with this special service.

It seems too vast a problem for the local board of education to handle.

However, it would appear to be of such benefit for agencies such as ours who have made a tremendous investigation, to meet these emotional problems to be able to complete our job by assistance in building up school facilities to meet the increasing educational and vocational problems referred to us.

We have evidence that the children who have been in these two specialized classrooms have profited from this experience. They have adapted to special classroom routines where they have been constantly observed and could not be tempted to leave.

We have had boys who have openly defied and threatened to assault the various public school teachers who now have a chance to know one teacher and through that relationship to develop trust.

Our two teachers have felt that in small classrooms they have been able to ferret out interests and talents in pretty inadequate students which the public schools do not have the time to do.

These children have gained enough confidence to try a little in other areas where they have previously felt inadequate.

We have countless children in these classrooms who were at one point incapable of staying in public schools, but later were able to return to public schools and adjust.

Our children have had severe emotional problems and poor educational background and incentive before they came to us. Although we wholeheartedly endorse high standard vocational schools and services with the broad scope of academic as well as practical courses, we find also a very urgent unmet need for supplementary vocational services for those children who have been handicapped, but must go out in the community after 16 years of age and earn a living.

We would, therefore, like to see funds for vocational training provided for treatment institutions.

We endorse the development of independent living workshops or rehabilitation services for handicapped persons over 16 years of age, referred to in bills 1119 and 3465.

We would also hope that residential facilities may be considered as important for these youngsters so that they might serve those gains which they might receive from these rehabilitative services through a situation which is both supportive and strengthening to them.

Our urgent question is not the growing need of special vocational and educational services for emotionally handicapped children so vast that it is beyond the resources of the local board of education and perhaps beyond the State capacity to finance unless Federal assistance is available, perhaps through a matching formula, that encourages State and local communities to take initial steps with at least token investment of their funds.

In summary, we give testimony to the need for additional special classrooms for the emotionally handicapped to the end that study and treatment services be rounded out with proper treatment, geared in education.

Two, we give testimony to the need for vocational schools geared to the practical goal of preparing children with lesser academic competence to learn a trade which will enable them to become self-supporting.

Three, we endorse independent living facilities for the handicapped with the suggestion that supportive group residences be provided in order to preserve the gains of these rehabilitative services.

Thank you very much.

Mr. ELLIOTT. Thank you very much.

Mr. GIAIMO. May I ask one question?

Mr. ELLIOTT. Mr. Giaimo.

Mr. GIAIMO. Is your school supported by public or private funds?

Mr. WEINER. It is a private agency.

Mr. GIAIMO. It gets no support from the State at all, does it?

Mr. WEINER. The support it gets from the State is through partial payment for board. In no case does any parent or State government through the State welfare department pay the full cost of care.

Mr. GIAIMO. Thank you.

Mr. ELLIOTT. Thank you, Mr. Weiner.

If none of our afternoon witnesses are here, we will adjourn until 1:30.

May I ask those of you who are here to cooperate with us in passing the word around to any possible witnesses that we are trying to finish by 4 o'clock this afternoon.

We have witnesses scheduled through 4:50, but if we can get word to those that we are speeding up our schedule a little bit, I think they will cooperate with us.

(Thereupon, at 12:10 p.m., the subcommittee was recessed, to reconvene at 1:30 p.m., same day.)

AFTERNOON SESSION

The subcommittee reconvened at 1:30 p.m., upon the expiration of the recess.

Mr. ELLIOTT. The subcommittee will be in order.

Somebody said that a "North wind doth blow and we shall have snow" and I am hoping that you will pardon me if I tell you I have in mind to seek the sunnier climes beginning about 4 o'clock.

First, I am going to recognize the Honorable Anthony C. Gelormino, mayor of Torrington, Conn.

Mr. Gelormino, will you come around.

He tells me he can make his statement very short and he needs to be somewhere else very badly and we will recognize him at this time.

STATEMENT OF HON. ANTHONY C. GELORMINO, MAYOR OF THE CITY OF TORRINGTON, CONN.

Mayor GELORMINO. Thank you, Mr. Chairman.

Mr. Chairman, members of your committee, I would just like to go on record as being in favor of your legislative bills to help the handicapped and unfortunate people of the country.

I would like to tell you just a little about Torrington. About a year and a half ago I appointed a committee on rehabilitation and aid to the handicapped. This committee consists of prime members of individual agencies, including State unemployment, our welfare department, directorate of health, and the various agencies which are doing their very best to aid the handicapped.

Also in the city of Torrington I do have a little bit of school, we call it a school, to help the exceptional children. They are primarily mentally retarded children and also various handicaps.

We are going to place another teacher on that who is being specially trained to conduct the courses in the school.

To date my committee on aid to the handicapped and rehabilitation is working very closely with the State rehabilitation centers. We have found in a survey recently that we have about 90 people that are in dire need of such type services.

We also find that with the knowledge of the residents of our area that such a committee does exist, that many people are coming out of obscurity and people who have been tucked away in homes for many, many years are coming out and registering with the hopes that they may be able to be helped.

I am very happy to report that we have made some progress. We are doing everything we possibly can to help these unfortunate people.

I was rather amused and amazed this morning when one of your colleagues questioned one of the people here who gave testimony, that we have a real unhealthy country with the multiples of people who are afflicted.

I do feel that what you are attempting to do will certainly eliminate a lot of that because there is certainly a lot of overlap.

Many of the different agencies have the same people on their records. I think there is mass duplication. That is the reason for my committee. We are a city with a population of just over 30,000 people. To date we have about half of 1 percent.

We are an industrial city. In addition to trying to rehabilitate and to aid these people, I have members of the committee, members of management and labor and chambers of commerce, so that we are also able after due evaluation and all the aid that can possibly be

given to make an attempt to find the handicapped person employment.

I sincerely urge the Congress of the United States to give favorable consideration to enactment of the proper type of legislation which will assist the communities and the towns and the States and the entire country.

We do need assistance. As yet we have not used tax dollars. If there is need for it I intend to budgetize a minimum amount and work from there, but I want to sincerely urge you to do everything you possibly can to get the proper legislation passed which will enable these unfortunate people to smile again and to live with dignity and independence and certainly to assist the domestic problems in their families so that they will not carry the cross alone.

My sincere thanks to all of you for the pleasure of being here and also my own personal congratulations to Congressman Giaimo for his effort to bring the committee here. I hope you will get enough evidence and information here to indicate that there is a dire need for that type of legislation.

Thank you, sir.

Mr. ELLIOTT. Thank you very much, Mayor Gelormino.

Now, Dr. Pasquale Confreda.

Dr. Confreda, we must limit you to not more than 10 minutes.

STATEMENT OF PASQUALE CONFREDA, PRESIDENT, PARENTS LEAGUE, RHODE ISLAND SCHOOL FOR DEAF, PROVIDENCE, R.I.

Mr. CONFREDA. Thank you for reminding me, but I think I can speed up the time. I have about 3 minutes.

Mr. Chairman, members of the committee, as president of the Parents League of Rhode Island School for the Deaf, and father of six children, two of whom are deaf, I wish to approve the recommendations made to the committee.

I wish to commend highly the work of Senator Lister Hill in introducing into the Senate Joint Resolution 127 and Representative John E. Fogarty for his work on companion bill 488 introduced in the House, and to the others who have worked for this important cause.

The teachers that I have known who have taught are dedicated to their work and it is miraculous the result they obtain under such difficult odds.

I am in favor of any grants-in-aid program to encourage more teachers to become speech and hearing therapists. The children in our country who are handicapped by deafness need the skill of specially trained teachers of the deaf to develop their ability.

We also need specially trained speech pathologists and audiologists to help those with speech and hearing impairment.

I endorse on behalf of myself and the Parents League of Rhode Island School for the Deaf, which I am representing, anything which may further this goal.

Thank you for the invitation to appear and speak to you.

Mr. ELLIOTT. Thank you very much, Dr. Confreda.

Is Mr. Victor Reis here?

Mr. Victor Reis is the chairman of the Rehabilitation Commission of Torrington, Conn.

Will you come forward, sir.
You may proceed.

**STATEMENT OF VICTOR REIS, CHAIRMAN, REHABILITATION
COMMISSION OF TORRINGTON, CONN.**

Mr. REIS. Thank you, Mr. Chairman.

I merely wish to state briefly that I would like to concur in the statement made by Mayor Gelormino so far as the city of Torrington is concerned. He covered it very, very adequately.

I just want to add that there is definitely a need for special rehabilitation and education here in the State of Connecticut. I not only speak personally of my own personal experience. For 11 years I conducted the program for the Veterans' Administration concerning prosthetic and sensory aids. I am very well acquainted with the dire needs that are presently quite obvious.

And not to take up too much of your time, as Mayor Gelormino indicated, we in the city of Torrington are definitely making an attempt to do our share for the purpose of rehabilitating these individuals that are in dire need of this particular type of training.

I at least hope that when you do return to Washington that a special effort will be made to enact the proper type of legislation which the entire country will be very proud of.

Thank you.

Mr. ELLIOTT. Thank you very much, Mr. Reis.

Our next witness is Mrs. Douglas T. Wilson, president of the Rhode Island Congress of Parents and Teachers.

Mrs. Wilson, you have heard me speaking of the time limitations, have you not.

Mrs. WILSON. I promise to abide by the rule.

**STATEMENT OF MRS. DOUGLAS T. WILSON, PRESIDENT, RHODE
ISLAND CONGRESS OF PARENTS AND TEACHERS**

Mrs. WILSON. I am Mrs. Douglas T. Wilson, president of the Rhode Island Congress of Parents and Teachers.

We welcome this opportunity to speak of some of the unmet needs in Rhode Island in the field of special education. The division of the State department of education that deals with special education is working constantly to improve these services in the public schools. However, throughout the work with the mentally and physically handicapped, and the gifted, there emerges a pattern of similar needs.

It is this pattern of unmet needs which the Rhode Island congress wishes to bring to the attention of the subcommittee.

1. All teachers should be trained to recognize problems: For any child to receive the benefits of existing special education programs it is necessary that his individual needs be recognized. The classroom teacher if trained to spot symptoms of trouble, is the logical person to set the wheels in motion to secure for the child the help he needs.

This applies to poor eyesight, poor hearing, and emotional disturbances. All of these difficulties are much more successfully treated if

detected early. The child's education may proceed and he remains a happy member of the community.

2. More teachers are needed in special education: Many more teachers are needed in all fields of special education. More teachers of the mentally retarded are needed. Some communities are having difficulty complying with the State law requiring instruction of the educable and trainable, because of the problem of transporting these children. If more teachers were available these communities might have smaller neighborhood classes nearer the homes of these children. Likewise more teachers are needed for children with partial vision.

There is need for more speech therapists in Rhode Island. It is estimated that the three thousand pupils assisted by speech therapy in the past year are only about half of those who need it, and there are undoubtedly many more whose need has not been recognized.

This past year about 14 school districts in Rhode Island have had some form of special program for gifted children. These communities are now beginning to feel the need for more teachers specially trained in this field.

3. Early evaluation, treatment, and follow-up of problems: In most Rhode Island communities a social worker is called to go to the home only when a problem interferes with attendance in school or disrupts a class. By that time the problem is far advanced.

Along with the need for teachers who are trained to recognize problems some program is needed to work with the home, to help parents understand and be impressed with the need for early treatment.

This points out a need for more school social workers. The role of such personnel in helping the child, the teachers, and his parents to understand his difficulty and to bring about changes necessary to correct the situation, should have more emphasis. The social worker's skill and experience can be valuable in assuring early treatment.

In the case of emotionally disturbed children, there is a need for follow-up care if the benefits derived from existing clinics are to be permanent.

The clinic staff is unable to follow these children into the home and the community. Lack of funds to provide sufficient resources for getting and keeping these children under effective care creates additional problems for the school and the community. House Joint Resolution 488, training teachers of the deaf, and pathologists and audiologists.

Policy No. 4 of the legislation program of the National Congress of Parents and Teachers states, in part:

Federal funds appropriated for education should be available for special programs for the education of handicapped children.

The Rhode Island Congress of Parents and Teachers favors the passage of House Joint Resolution No. 488.

There are at present 23 speech and hearing therapists working in the public schools in Rhode Island. It is estimated that a minimum of 50 additional ones are needed.

There are at present no facilities in Rhode Island for training speech pathologists and audiologists. While it might be desirable to establish such a training center in Rhode Island, we are aware that large expenditures for an extensive faculty and teaching equipment would be required.

If facilities in nearby States are not being used to capacity, our needs may be filled by encouraging enrollment of more Rhode Island residents in these centers.

If this bill passes, it is hoped that the existence of the fellowships that will be established will be widely publicized so that Rhode Island residents might hear of them and apply. Regarding H.R. 1119 and 3465, The Rhode Island Congress of Parents and Teachers favors H.R. 1119, independent living. In so doing, we are furthering the action program of the National Congress of Parents and Teachers which is concerned with the prevention.

In this case it is the prevention of institutional care for those handicapped persons who may be restored to independent living.

The Rhode Island congress favors the provision of this bill which removes the restriction that a person must be progressing to employability before the vocational rehabilitation program can be applied.

Progress of an individual as far as becoming self-sufficient at home and thus able to stay out of an institution is in itself desirable. And this is economically sound.

In Rhode Island we are in the midst of a \$10 million expansion program at the Ladd School for retarded children. It is estimated that unless we can help the adult mentally and physically handicapped to independence we will be faced with the expenditure of another \$20 to \$30 million for institutions for their care.

Further, it may well be that the workshop plan as a preemployment experience will assist many more handicapped persons to progress to employability than at present.

Thank you again for this invitation to present our views here.

Mr. ELLIOTT. Thank you very much, Mrs. Wilson for a very fine statement.

Is Dr. Josephine Rathbone here.

Miss RATHBONE. Yes, sir.

Mr. ELLIOTT. Dr. Rathbone, is formerly director of recreation in rehabilitation, Teachers College, Columbia University.

You may proceed.

STATEMENT OF JOSEPHINE RATHBONE, FORMERLY DIRECTOR OF RECREATION IN REHABILITATION, TEACHERS COLLEGE, COLUMBIA UNIVERSITY

Dr. RATHBONE. Gentlemen, today it is my great pleasure to present the Consulting Service on Recreation for the Ill and the Handicapped of the National Recreation Association.

We are not here to quarrel with any concept enunciated in bill H.R. 3465, except possibly the implication that grants shall be forthcoming only when assurance has been given that the facility or program is "feasible and necessary for vocational rehabilitation"—page 6, section 203(a) (1) and page 17, line 20, even outside the competitive labor market, page 15, line 17.

We see independent living as meaning something different from vocational self-sufficiency, for many severely handicapped and older persons, page 2, lines 3 and 4.

Health and the American Public Health Association are among the national bodies that have studied the opportunities, the responsibilities and the measures to be taken, along with the costs and the dividends.

Our Connecticut White House Conference Committee for Children, 1959, and our new White House Conference Commission on Aging are directing specific attention to these problems.

4. A few comments may be made, and questions raised concerning some of the bills which have come to attention.

On January 7, 1959, and on January 27, 1959, were introduced bills H.R. 1119 by Mr. Fogarty and H.R. 3465 by Mr. Elliott, respectively, both "To provide evaluation of rehabilitation potentials and rehabilitation services to handicapped individuals who as a result thereof can achieve such ability of independent living as to dispense with the need for expensive institutional care or who can dispense with or largely dispense with the need of an attendant at home to assist in the establishment of public and private nonprofit workshops and rehabilitation facilities and for other purposes."

The purposes are clear and indicate foresight in developing planning. In section 2(a) of H.R. 1119, an amendment is obviously related to Public Law 565, 83d Congress, chapter 655, 2d session, S. 2759, an act. Provisions for grants under section 202(g) title II seem to be clear. Under section 203, page 7, is a new State rehabilitation agency intended in lines 11 and 12? Improvement of conditions in existing agencies in a manner to provide for joint planning and cooperative action and adequate medical guidance will be important; and it is hoped that multiplication of State agencies will be avoided. The preparation of a "flow chart" and of methods for distribution of authority and funds in some localities will show the confusion and cumbersomeness of too many "cooks", often operating somewhat independently even though the intention is to benefit a handicapped person and a family. On page 12 of this bill, page 12, under definitions, and the same in H.R. 3465, what is meant by "therapeutic treatment"? Does this include medical advice, prescription, and supervision? On page 13 of these bills, line 2, will he "no longer require such institutional care", or that such care and attendance may be substantially reduced, or does this imply no care as referred to possibly on page 2, (b), line 10 and 11?

On page 15, (b)—in considering "but not be limited to * * *" reference may be made to paragraph (B) on page 15 as to relationships. Possibly this might state something such as: the following provided they are under medical direction, or supervision, with prescription. Among the ideas here is the question if there is enough reference to medical guidance.

Turning to the good House Joint Resolution 316, of Mr. Fogarty of March 19, 1959, paragraph 2 of page 1, does the term remediable in 80 percent of the cases refer to medically remediable or to other factors? In paragraph 3, is the definition of rehabilitation worker clear in this context? On page 2, should emphasis be given under reference to training that this can be done best in a medical setting, preferably in affiliation with a medical teaching institution? On page 3, reference to medical supervision is lacking. On page 4, is it practical in lines 6 and 7 to include a medical practitioner? When we see the value given by Dr. Krusen in the Office of Vocation Rehabilitation recently, we see great possibilities. On page 5, section 4, advisory committee, members "shall be chosen from" etc. This is good but is not in the Elliott bill—House Joint Resolution 494. Is a person in physical medicine desirable? In House Joint Resolution 494, is there sufficient provision for medical help and advice? (e.g. p. 4, lines 13-20.) On page 5, lines 11-17, no M.D.'s are mentioned.

5. ILLUSTRATIVE HISTORIES

(a) My attitude, both personal and professional, toward comprehensive rehabilitation was profoundly influenced by an intimate and impressive experience I had with a college student and his family. He lost the sight of one eye, had both hands blown off, and suffered other injuries in a laboratory explosion in 1938. The initial effect of this accident, in the midst of his professional education, was shattering to his morale and greatly handicapped him physically and in building a satisfactory career, but through sympathetic and highly skilled assistance that was fortunately available to him, he went on to complete a Ph. D. degree in chemistry and has become internationally known in the highly technical field of combustion, in its application to jet engines, rockets, etc. He drives his own car and travels extensively by himself, in the United States, Europe and

the Far East. He has achieved a happy home life, is the father of two boys who he joins frequently on skiing outings, and is active in his church and the social life of his community. The native intelligence and courage that this man possessed contributed greatly to this happy result, but it is very doubtful if these would have been nearly as effective without the understanding, encouragement and training received from rehabilitation personnel.

(b) Two case histories from the experience of a former Welfare Fund Medical Director, now a hospital director, will illustrate this further.

Case 1.—A 37-year-old woman became aware of increasing weakness and numbness in her legs and a few months later she was unable to walk. The diagnosis of a small hospital in another State was multiple sclerosis, with loss of sensation and use of legs. As many of you know, the cause of this disease is not known, but sporadic patches of scar tissue develop in the brain and/or spinal column, causing a variety of disorders.

The Welfare Fund referred her to a rehabilitation center, where a diagnosis of spinal cord tumor was made and a successful operation removed a benign tumor close enough to the spinal cord to have caused the symptoms.

She is now a healthy woman having avoided the life of a severely handicapped person because of this evaluation. The cost to the fund was \$1,000, but the cost to the community for her care would have been many times as much if she had not received a sound diagnosis and excellent management for an unexpected condition.

Case 2.—An 11-year-old girl developed slowly progressive weakness of her legs in July, 1945. In 1949 her situation was brought to the attention of the fund by her family physician. The diagnosis, muscular dystrophy—another disease of unknown causes—gave little hope to all concerned.

She was sent to a rehabilitation center in March 1949, where a deficiency disease that can be controlled by regular medication, was diagnosed. She was discharged within 2 months "very nearly a normal girl, as long as she continues to take regular doses of a medicine—prostigmine. She finished her high school education, married in 1953 and has three healthy children. At a cost of less than \$3,000 and because of a thorough evaluation, she is living a normal life and avoiding the suffering and expense of disability.

(c) Prior to my becoming a member of the board of directors of Gaylord Farm Sanatorium, its services had been limited to the care and rehabilitation of persons afflicted with tuberculosis, for which it had an outstanding reputation over some 50 years, under the direction of a wise and skillful and understanding physician, Dr. David Lyman. Since this disease is being brought under control through improved treatment, Gaylord has had an opportunity to broaden its field to include rehabilitation services for persons having any remediable disability. I will now cite three case histories from our experience there, that I think will be helpful to the committee.

Case 1.—A 64-year-old man was admitted in December 1956 with his left leg amputated above the knee, diabetes in mild form and congestive heart failure due to an insufficient supply of blood to the heart muscles. A year prior to admission his wife had died, after prolonged suffering, from cancer. Since her death he lived alone, ate irregularly at various restaurants and never regained interest in living. His diabetes got out of control and possibly because of this, his left foot became so badly infected that his leg had to be amputated above the knee.

Following amputation, he was admitted to Gaylord in no mood for vocational rehabilitation or independent living. Readjustment to the point that a nursing home could handle his medical and social needs seemed about the best that could be expected.

This man was a patient from December 28, 1956, to June 28, 1957. He received daily medical supervision; rehabilitation nursing; frequent laboratory studies; physical, occupational, and work therapy; social service; vocational counseling and guidance; planned social activities; a therapeutic diet, and practical instructions about the preparation and selection of food.

As the treatment progressed, the patient began to develop higher goals for himself which he "sold" to the Gaylord staff and to the Connecticut Bureau of Vocational Rehabilitation.

Men in their 60's are often unable or unwilling to use artificial limbs, but we found in this man such a desire for self-sufficiency that an artificial leg was purchased for him by the Bureau of Vocational Rehabilitation. While the patient was not well coordinated, he was so well motivated that after several

weeks he could walk. Today, he is living alone in a small neat apartment, where he does all of his own housekeeping and cooking. The rest of his story is best told in his own words in the following letter which I received from him under date of June 9 of this year.

"DEAR DOCTOR: You will, I am sure, be glad to hear from one of your former patients, a patient who was brought under your charge on a stretcher, with very little expectation of ever being thankful for anything or anybody.

"Today I am glad to inform you I am employed in a business office, drive a car, have paid back to the State welfare the money they advanced for my hospital care, and am paying the bills accumulated during my wife's and my illness. All this I attribute to the treatment I received at your institution—the physical therapy, the medical care, the personal attention, and the followup after I left Gaylord. Again I want to thank you for what you did for me and are doing for others. Gratefully yours."

I would like to remark here that rehabilitation is not the most remunerative field open to the doctor of medicine and one engaged in it who does not get a big lift out of such a letter would do well to change to a field where the remuneration is paid entirely in money.

Case 2.—A 37-year-old woman with three children under 9 years of age was admitted to Gaylord on February 22, 1956. A college graduate, with a master's degree in music (piano), she had taught for several years. She was disabled by a devastating disease, lupus erythematosia, which had affected her nerves, joints, and internal organs, causing severe pain and paralysis of muscles. She could not move any muscles below her knees or lift her arms above shoulder level; her fingers were partially paralyzed.

At the time of her admission there was little hope of her return to her family in a useful capacity and no hope for her to again teach piano. The family situation was chaotic; her mother attempted to take care of her three small children. Her husband was unable to carry out his job to the best of his ability because of demands at home and concern for his wife.

For many months she had an "up and down" course; with her considerable courage and determination, thoughtful physician management, intensive nursing care, physical and occupational therapies, she was finally able to return to her home. Upon her discharge on March 25, 1957, after more than a year of hospital care she could walk with two short leg braces free of pain. She tires easily, with with scheduled rest she manages her home, her children, and is again teaching piano. Most important, she is home with her family, without need of daily medical care.

Case 3.—A 19-year-old boy was admitted June 20, 1956, with a 2-year history of Guillian-Barre syndrome—a disease affecting the body's nerves, which is marked by pain, tenderness, and weakness in the muscles supplied by the affected nerves. After staying 9 months at a medical center and 1½ years at a chronic disease hospital, he came to Gaylord so limited in his abilities that his only diversion was painting by holding the brush in his teeth. There had been no noticeable progress during these 27 months.

The goal was to teach him to live independently. Special devices were prescribed so he could increase his usefulness. Daily physical therapy also served to prevent contractures at the joints. His muscle strength gradually improved. Special devices became unnecessary. Our reevaluation gave us confidence to plan even beyond the goal of independent living—useful employment.

One year after admission he was discharged, completely independent. Using one cane, he attended his high school graduation. For the past year he has been employed by the Fuller Brush plant in his hometown.

This successful rehabilitation required the cooperation of 15 separate services, as well as the patient and his family.

General methods employed

The above specific cases are generally typical of the methods employed at Gaylord.

We feel that a large number of highly trained, highly skilled services are required for the best results. In addition to a full-time staff of doctors, nurses, therapists of various kinds, and social workers in the several categories of human need, we are fortunate in having a consulting staff of outstanding specialists from the New Haven area who visit Gaylord twice a week to consult with the full-time staff on special problems. With this staff, we feel we have the best advice available on almost any condition that may be encountered.

We also maintain close working arrangements with several medical centers, including the Grace-New Haven and Hartford Hospitals; all of Connecticut general hospitals; and all voluntary and special agencies offering related services. Following discharge from Gaylord, the services of family physicians, visiting nurse associations, and rehabilitation centers, such as those established in New Haven, Hartford, Stamford, and Meriden, are freely used and have proven most effective.

In addition to the above, we feel that it is very important that a patient's skills, his remaining abilities, or his potential abilities, should receive imaginative consideration and for this purpose a workshop equipped with a variety of machines and hand tools, is invaluable. Gaylord was fortunate in receiving a special grant from the Office of Vocational Rehabilitation in July 1958 for developing such a shop. This shop enables the staff to measure and develop work tolerance while exploring work skills, but most important is the effect on a patient's morale of finding himself able to do useful work. It banishes the enervating feeling of uselessness and dependency and gives him the courage to seek self-support.

Mr. GIAIMO. Dr. Robcliff V. Jones, Jr., associate in physical medicine and rehabilitation, University of Connecticut, will be our next witness.

H. Kenneth McCollam, executive secretary, Connecticut Board of Education for the Blind, and Guy Marchisio, chief, Children's Service, Connecticut Board of Education for the Blind.

**STATEMENT OF H. KENNETH MCCOLLAM, EXECUTIVE SECRETARY,
CONNECTICUT BOARD OF EDUCATION FOR THE BLIND, HARTFORD, CONN.**

Mr. McCOLLAM. I am H. Kenneth McCollam, executive secretary of the Connecticut Board of Education for the Blind.

I am going to speak briefly from the braille outline that I have before me.

If I may, I request the permission of the committee to file a copy of what I am going to say and try to cover at a later date.

Mr. GIAIMO. Without objection, you may.

Mr. McCOLLAM. I would like also to cover briefly the rehabilitation aspects of the discussions that we have before us and ask Mr. Marchisio to follow me with a summary of the matters pertaining to special education.

I want to open by expressing gratitude to the committee for the privilege of coming before you and also for the rare privilege that I think all of us had in sharing in the workshop study group that has been held in the previous 2 days in New Haven.

In connection with that, I think it gives those of us who at the agency level work with the blind a rare opportunity to meet with people of all interests in work for the blind, including, as Mr. Istas pointed out, people representing the Federation of the Blind and others with whom we sometimes have difficulty in sitting down with and sharing their thinking.

This has been a very worthwhile meeting and I think all of us have gotten a great deal out of it.

In connection with that, I wish to go on record here in favoring the report submitted by the workshop project by Mr. Greehan and we thoroughly endorse all of the proposals that were presented by him.

I would also like to go on record in favor of the bill for independent living as presented in 3465. We feel that that is a type of legislation

that is seriously needed in work for the blind in particular, although it has many great benefits to other types of handicaps than the blind.

We feel that the rehabilitation setting and the training that agency people have would be the proper place for the administration of the independent living provisions.

I would like further to recommend that the opportunity for training of personnel through grants, through traineeships, or through any of the many other avenues for obtaining specific training in the areas of the handicapped be encouraged and promoted in every way possible.

As many of you have already been told by other people who have presented their view here, there are a great many areas in which there is need for skilled professional workers working with the handicapped groups.

One particular group that I wish to mention particularly would be that of mobility trainer. We all know the difficulty that presents itself to any blind person in getting about. In recent years there has been developed a skilled mobility training and getting about by the use of cane or other recognized methods of guidance.

There has been no place in the country up to this point where a person may be trained in the skills which he could then later impart to blind clients.

If at all possible through the provisions of any of the bills before us we would urge that attention be given to this particular lack.

There has been a study made recently by the Office of Vocational Rehabilitation in conjunction with the American Foundation for the Blind in this area, and we hope from that will come some definite proposal.

Another point that I would like to emphasize again in the field of training, the need for a type of apprenticeship training that might be possible wherein a well trained, from an educational or academic point of view, a well trained individual, who may come out of one of the courses that Congress has made possible through the extension of the Vocational Rehabilitation Act, come out with a master's degree, but with no practical application of the theory that has been learned and learned well.

What I would suggest here is that Congress, through extension of the Vocational Rehabilitation Act, make possible grants which could be used for the financing internship or apprenticeship type of course in the States whereby these college graduates, oftentimes with a master's degree, can obtain a practical experience necessary to make them a worthwhile worker in the field of work for the blind.

The reason that the State cannot always do this or accomplish this very thing is because of the limitation of budgets, also the fact that there are serious restrictions on the matter of taking a person on your staff and then having to put him through a lengthy training period or internship.

I would also like to speak briefly on the broadening of the provisions of the Hill-Burton bill, which would encompass the establishment of rehabilitation centers, possibly not medically oriented or medically backed, but the type of center that would provide to blind people throughout the country the facilities that they are so rarely lacking in the field of prevocational and vocational training.

We have centers throughout the country for adjustment to blindness. The number of centers or places where we can expose blind clients to prevocational training or limited vocational training as well as the exposure to the various social needs of the individuals are lacking to a very high degree.

In the New England region some studies have been made by the Office of Vocational Rehabilitation with the thinking that perhaps a regional center might be established.

The numbers that have been indicated on the basis of this study are relatively small and it seems that it might not be feasible for a regional center for the blind alone.

I would welcome any thinking that might be possible in following out the recommendations of one of the previous speakers that a rehabilitation center on a regional basis for other types of handicap might also include the rehabilitation and training of blind individuals.

I would also like to endorse the recommendation made by Mr. Mungovan of Massachusetts at the hearing yesterday on the matter of the withdrawal of the need for applying the means test for readers for blind students.

That has presented a great deal of difficulty. We are allowed under the provisions of Public Law 565 to pay for tuition for a blind student without necessarily applying the means test. When we have to provide him with readers in order to obtain the education that he needs, we do have to make the application of the means test under the present provisions.

I would like very much to see that changed if at all possible.

In the interest of time I think perhaps now I will relinquish the balance of the time that has been allotted to me to Mr. Marchisio to deal with the special education.

Mr. GIALMO. Thank you, Mr. McCollam.

May I say to you, Mr. Marchisio, in the interest of time will you summarize your statement as best you can and then leave your prepared statement with us.

(The statement referred to by Mr. McCollam follows:)

OUTLINE OF NEEDS OF BLIND PERSONS IN CONNECTICUT AND PROPOSAL FOR CHANGE IN EXISTING LEGISLATION

(By H. Kenneth McCollam, executive secretary, Board of Education of the Blind,
Hartford, Conn.)

The board of education of the blind is an independent State agency charged with the responsibility of bringing multiservices to the blind of Connecticut. The register of known blind persons contains the names of some 3,700 individuals. The current budget of the agency calls for the expenditure of \$600,205 annually and of this amount \$327,200 is expended for education of blind children.

Representatives of this agency had the privilege of sharing in the 2-day workshop sponsored by the study committee established under the subcommittee of Congress and wished to go on record as endorsing the proposals submitted by Mr. Frederick D. Greehan, chairman of the section working with the visually handicapped.

The agency would further wish to be recorded as in favor of the passage of the independent living bill 3465 that is presently before Congress. It is the belief that the needs of blind persons could best be met by the administration of this new program through the well-established and professionally staffed personnel of the agency presently carrying out the provisions of the vocational rehabilitation program.

In order to meet some present gaps existing under the Vocational Rehabilitation Act of 1954 (Public Law 565), it is further recommended that Congress make available training grants to universities or colleges to establish training programs for mobility instructors for the blind. The need for mobility is probably one of the greatest in work for the blind that exists at the present time. Attempts through organizations such as the Hines Hospital of the Veterans' Administration and a few additional provide adjustment centers to meet this need; but the number of trainees that they are able to accept is so limited that years will be required to begin to meet the need in the several States. It is estimated that Connecticut might well use the services of two or more mobility instructors on a full-time basis, if properly trained personnel were available.

A secondary training project which seems highly desirable in the effort to obtain well qualified and trained personnel in the various areas of work for the blind, is the need to establish a training grant available to the several States that would provide the adequate compensation for an apprenticeship trainee for a period sufficiently lengthy to give him the much needed practical experience in the area of work for which he had been academically trained. Many persons are utilizing the training privileges under Public Law 565 to obtain master's degrees in vocational rehabilitation but have no opportunity to gain practical field experience that would enable them to be employed directly by a State agency. Most State agencies require at least 1 year of experience beside the college education.

It is suggested that the Hill-Burton law be amended to permit the use of the funds available under its provisions to be used for establishment of a rehabilitation center that would include prevocational and vocational training over and above the medical services which are presently required. It is suggested that studies be made to determine the need for such rehabilitation centers on a regional level and of a nature that would offer services to blind clients as well as to those of other handicaps.

It is recommended that a study be made of the application of the formula for allocating funds under Public Law 565 to reflect the need of certain States with a high per capita income who are receiving meager allocations of funds under section 11 of the allotment, which involves additional support funds available to the States as a whole. For example, in Connecticut, over the past 4 years when rehabilitation funds to the States in general have risen from \$23 million to \$53 million, this State has received only the following amounts of these funds:

1956	\$63, 045
1957	58, 322
1958	48, 885
1959	44, 899

It is recognized that the general application of the formula used in allotting funds to the states is generally acceptable to the country as a whole. It could be readily seen, however, that the great benefits derived by States with lower per capita income are being denied to Connecticut where despite the financial well-being of the State in general, there are limited funds available for vocational rehabilitation purposes. It is suggested that some thought be given to providing additional funds over and above the formula quota that could be made available on a State-matching basis of dollar for dollar.

This agency would also favor the removal of the requirement under the regulations of Public Law 565 of application of the means test to the provision of reader services to blind students. This regulation does not seem to be consistent with the payment of tuition fees without application of the means test, while at the same time the necessary reading service to permit a blind student to pursue his studies should be so stipulated.

It is further recommended that the provisions of the aid to the blind be modified so as to permit a larger amount of earned income to be exempt before an AB grant would be modified. The original provisions of the act stipulated that \$50 a month of earned income would be exempt. It is recommended that this exemption should be amended to read \$100 of income from any sources be exempt.

This agency wishes to express appreciation and gratitude to the committee for making it possible to appear and to participate in the workshop and hearings in connection with its study. It is further requested that this written report be made a part of the congressional record of the hearings.

STATEMENT OF GUY MARCHISIO, CHIEF, CHILDREN'S SERVICES,
CONNECTICUT BOARD OF EDUCATION FOR THE BLIND

Mr. MARCHISIO. Mr. Chairman, gentlemen of the committee, I would like to say initially that these points that I presented, these recommendations, although given to you from the point of view of Connecticut, I believe they apply pretty much to the whole country.

We have some eight points. We are asking that Federal help be given in the preschool area.

Very few of the States have sufficient funds particularly to help parents with the problem of blindness in children. Very few States, including Connecticut, have outright funds for this program.

We think this should become a definite part of the educational program. This is true of blind children as well as any other children where not only do you need help to assist the parents but a more formalized type of service is needed in terms of getting the children ready before school.

Two, the establishment, as has been mentioned here several times, of the regional diagnostic and treatment centers. The centers, particularly for multiple-handicapped children.

I would like to stress multiple-handicapped blind and also emphasize the emotionally disturbed ones. This is likely to be an area that is omitted in the states where the service is for physically handicapped, but not for the emotionally disturbed or people with emotional problems, with the additional handicap of blindness.

Three, again I think you have heard on this, the establishment and award of scholarships and graduate fellowships, not only on the university level. I am a little concerned about this, having taught at the university level myself, and this can become quite theoretical.

I think there should be two additions added to our scholarships, two phases:

One, that these also be given on a part-time basis as well as a full-time basis; that is, a person who is already working on the job, particularly in the teaching field where training is very expensive and salaries are not too high, and also in terms of practical knowledge.

Scholarships for training centers, for traveling to agencies and centers to see what is going on, this type of thing, as well as university training.

Four, I would like to read this one.

(A) Increase the Federal quota grant substantially above the \$30 per pupil basis with a formula that will not place the smaller States at a great disadvantage.

(B) Distribution of the Federal quota grant to additional and varied manufacturers of educational materials and equipment for all visually exceptional children.

(C) Provision for proportionate representation from both public school and residential school personnel (ex officio members of the board of trustees) in the administration, selection, manufacture, and distribution of materials and equipment from the American Printing House for the Blind.

Now, our fifth point is asking that statistics be included in the census.

I think you have heard from this one before, particularly in the light of the population, the age distribution and the job classification of all legally blind people.

Six, a redistribution of the regional libraries for the blind.

The State libraries where you actually have a reflection of the State needs.

A recognition that blindness is not total blindness alone, that these libraries should distribute large print materials to partially seeing people, particularly in the literature, the nontextbook line.

Seven, the serious dearth of large print textbooks and other literature, after decades of sporadic effort, remains one of our most urgent problems to be solved as far as the partially seeing child is concerned. Many people have tried to tackle this and do something about it, but very little has been done. If you find that the States cannot lick this problem, then perhaps this is the time for the Federal Government to step in.

There is nothing, very little in the literature, in the recreational reading line, of large print books. We are asking here that the Federal Government make a study and perhaps distribute this material from the American Printing House and through the Library of Congress or grants to States.

Finally, I would like to preface my remarks on this one because I have been a great booster for volunteers in the area of blind people, of helping to transcribe braille books and so forth.

In fact, I am on the board of trustees of the national organization and also very active on the executive board of the National Braille Club, so I would like to show appreciation of what the volunteers have done and there is a place for them.

However, my point is that the blind are almost the only group of handicaps that have to depend on volunteers in their formal education. Therefore, we say legally blind children are entitled to an education at least equivalent to the education they would have had if they could see sufficiently well to do their schoolwork in the usual way.

In this regard the Federal Government should seriously consider the possibility of paying for the materials ordinarily provided by volunteers, thus instituting a service adequately designed to meet the need, when needed, and without fostering the very charity that has followed the blind individual through the ages.

This may be done through direct grants to the States, through agreements with publishers, or through the Library of Congress or American Printing House for the Blind acting as a clearinghouse for subcontracting orders from the States.

Thank you very much.

Mr. GIAIMO. Thank you, Mr. Marchisio.

(The statement referred to follows:)

A STATEMENT CONCERNING EXPANDED SERVICES TO VISUALLY HANDICAPPED CHILDREN AND YOUTH BY THE FEDERAL GOVERNMENT

(By Guy J. Marchisio, chief of children's services, State Board of Education of the Blind, Hartford, Conn.)

There are a number of unmet and partially met needs to blind and partially seeing children and youth in which the Federal Government may help and in which the States are finding it difficult to provide services.

1. Recognize the preschool service to blind and partially seeing children as an adjunct to formal education by providing Federal matching grants to the States in a phase of the work lacking sufficient funds for stimulating early preparation for school. Such a service should include individual instruction and counseling to parents and children as well as nursery school training.

2. The establishment of regional diagnostic and treatment centers and the provision of such services within presently recognized facilities through Federal grants to the States for building and staffing facilities for minimal-cost service for multiple-handicapped children and blind and partially seeing children with additional handicaps, to include visually handicapped children with emotional problems.

3. Substantial scholarships and graduate fellowship aid for the personnel concerned with all phases of education of visually exceptional children on both a full- and part-time basis. Some Federal grants are available for this purpose on a full-time basis, but little or no funds are provided for staff development in a field where salaries are low and cost of training is high. Similar grants are now available to vocational rehabilitation staff in the several States under the Vocational Rehabilitation Act 4A1—special projects grant.

4. (a) Increase the Federal quota grant substantially above the \$30 per pupil basis with a formula that will not place the smaller States at a great disadvantage.

(b) Distribution of the Federal quota grant to additional and varied manufacturers of educational materials and equipment for all visually exceptional children.

(c) Provision for proportionate representation from both public school and residential school personnel (ex officio members of the board of trustees) in the administration, selection, manufacture, and distribution of materials and equipment from the American Printing House for the Blind.

5. Provision in the Federal census for accurate statistics on the population, age distribution, and job classification of all legally blind individuals in the United States and in the several States.

6. Redistribution of the regional libraries for the blind to State libraries for the blind that reflect State and community needs. A recognition that blindness is not total absence of sight through the distribution of large print books as well as braille and recorded literature by these libraries. A speedup in the number and variety of talking book records for children is urgently needed.

7. The serious dearth of large print textbooks and other literature, after decades of sporadic effort, remains one of our most urgent problems to be solved as far as the partially seeing child is concerned. It is highly recommended that the Federal Government, through quota grants, extend this service to both the legally blind and true partially seeing child and that extensive research be initiated for obtaining the exact title requested, nonbulky books, most appropriate size type, and multicolored photographs and pictures.

8. Legally blind children are entitled to an education at least equivalent to the education they would have had if they could see sufficiently well to do their schoolwork in the usual way. In this regard, the Federal Government should seriously consider the possibility of paying for the materials ordinarily provided by volunteers, thus instituting a service adequately designed to meet the need, when needed, and without fostering the very charity that has followed the blind individual through the ages. This may be done through direct grants to the States, through agreements with publishers, or through the Library of Congress or American Printing House for the Blind acting as a clearinghouse for subcontracting orders from the States.

Mr. ELLIOTT. Has Mr. Arthur L. DuBrow come in? If not, our next witness is Dr. Charles J. Klim.

Is Dr. Klim here?

Dr. KLIM. Yes.

Mr. ELLIOTT. Come around, Dr. Klim.

Dr. Klim, our time situation is such, with 40 witnesses today, that we will have to place a limitation of 10 minutes on your statement.

With that understanding, you may proceed, sir.

**STATEMENT OF CHARLES J. KLIM, ASSISTANT PROFESSOR, SPEECH
PATHOLOGY, EMERSON COLLEGE, BOSTON, MASS.**

Mr. KLIM. This will average seven, perhaps.

Emerson College in Boston was one of the first college units in the country to train students as speech teachers, speech pathologists, and audiologists.

It has its own speech and hearing clinic where students receive the training and supervised practice as a necessary part of their preparation for certification in the field of speech and hearing.

At the present time there are 135 children and adults seen weekly at this clinic. Lack of physical space and staff limit our services. We want to expand this facility for the public.

The college also provides part-time speech and hearing help for the industrial school for crippled children in Boston, Tufts University Cleft Palate Clinic, Sullivan Square Medical Center, Holy Ghost Hospital in Cambridge, Woburn Public Schools, and Boston Dispensary which serves the New England Medical Center as a whole.

These programs exhaust the time of our present staff. We are appealed to regularly to survey school systems for need in speech and hearing. We do what we can, but have to turn down appeals for help due to lack of staff and equipment.

Easter Seal Club, cerebral palsy groups, and medical clinics continually ask for speech and hearing service from us. We do not have the help to offer help in speech and hearing.

Even New Hampshire clinics call on us regularly for service. In order to keep up the high standard of training for our undergraduate students in speech and hearing and to keep our clinic adequately supervised, our graduate program in speech and hearing has been slow in advancing.

We are being pushed to offer more to graduate students who want to receive higher certification. We need and want to meet this demand.

We now lack the space and staff to expand. With additional funds we could provide immediately the staff and the equipment necessary for the people who will want advanced training.

Our college clinic has a waiting list for people who need speech and hearing therapy. Expansion of our graduate program would mean increased therapy service to the community. It would mean a place where more bachelor degree students could obtain advance training. It would mean also that many students of speech and hearing would stay in the Boston and New England area to obtain their training instead of leaving for outside of New England and there to study and eventually settle.

The theory is that if they study in New England, they may stay there. With the excellent training facilities connected with the college in regard to speech and hearing, the opportunities for research are excellent. We have not been able to study and to evaluate the many therapy techniques or ideas which may have clinical value; it may be because of our lack of funds to provide the staff.

We do have the cases. If we had adequate funds we could put to immediate use two more advanced certified people on our staff on speech. We could use another full-time person in hearing if we had funds.

Our facilities are now inadequate. We need soundproof rooms for hearing. We need to double our space in order to better serve our speech therapy clients.

We need to provide more in the way of parent education. We have been requested time and again to provide therapy for adult cerebral palsy groups and other adult groups.

We have been called upon to help guide the more rural areas of northern New England especially in regard to setting up programs to meet the speech and hearing needs of smaller communities.

These are critical needs. With money and staff we could do much more to provide initial guidance and survey than we are now able to do.

Two years ago Emerson College conducted a workshop in the speech and hearing needs of rural areas in New England. The gathering of people who attended to testify as to the specific needs in their communities revoiced what was generally known. They were unanimous in voicing a need for education of parents in the areas as regards speech and hearing and a critical need for diagnostic evaluation by qualified therapists and a drastic need for qualified therapists to provide regular therapy in the rural areas.

Today the need in these areas is just as great and just as critical as 2 years ago.

The colleges in New England need funds to provide the increased staff and to recruit students who could fill some of these needs upon graduation.

The students who graduate from our college have no difficulty gaining employment. The number of positions far exceeds the number of graduates who have been turned out annually.

This picture will continue in spite of increase in graduates.

My own introductory course in speech and hearing this semester has 62 students enrolled. These are potential therapists. This is our largest single class.

We hope this kind of increase will continue. Nearly half of these at this early point in training have voiced a desire to go into graduate training in speech and hearing. They are faced with a real problem of finance on the graduate level. The expense of undergraduate training alone today is all that most parents can afford. This is where most parents stop.

In order to go to graduate school the student must support himself. This is difficult. To encourage them we need fellowships, traineeships, and grants for some years to come to help them continue their studies. Federal grants would be most welcome. They are now and will be desperately needed in New England.

Thank you.

Mr. ELLIOTT. Thank you very much, Dr. Klim.

Are there any questions of Dr. Klim.

Thank you, Doctor.

Our next witness is Mr. L. P. Simons. Is Mr. Simons here?

Mr. Simons, I regret that it is necessary that we impose time limitation of 10 minutes.

Mr. SIMONS. That is all right. Most of the material I will present is in the document you have. I will abstract it.

Mr. ELLIOTT. Without objection, the complete statement of Dr. L. P. Simons will be made a part of the record, following his oral presentation.

You may proceed, Mr. Simons.

STATEMENT OF L. P. SIMONS, EXECUTIVE DIRECTOR, EPILEPSY INFORMATION CENTER, BOSTON, MASS.

Mr. SIMONS. Thank you.

Of the 1,500,000 epileptics in the United States fully 80 percent have seizures eliminated or reduced to a minimum. Translated in terms of employment this means that 80 percent properly can be employed in competitive industry.

Unfortunately, being able to work does not mean the epileptic can find a job. There are many industries that will not hire an epileptic even if completely controlled, let alone employ him if attacks occur as frequently as once a year.

The employers offer the following reasons as to why they cannot hire an epileptic:

One, that he has a high enough accident rate.

Two, that his workman's compensation rates automatically rise when an epileptic is employed.

Three, epileptics have a high absentee rate.

Experience has demonstrated, both through research and on-the-job experience, that this just is not true.

For example, in 1958, the Ford Motor Co. in Dearborn, Mich., reported not one accident out of 165 workers with epilepsy.

In 1951, the U.S. Department of Labor study demonstrated there is no significant difference between the disabling and nondisabling accident rate of epileptic and nonimpaired workers.

The workman's compensation board in New York found that the average number of closed cases involving epileptics was only 10 out of 100,000.

It would not seem that people with epilepsy are particularly accident prone.

As far as workman's compensation rates, rates are based on experience rather than whether handicapped people are employed?

It was found also in 1951, the U.S. Department of Labor study, that epileptics actually lost less time because of accident than the nonimpaired worker.

The problem of the epileptic in industry seems to be primarily that of education. We know that the epileptic can work. They find it difficult to get a job.

I would like to propose a three-point program that the Federal Government do undertake to show leadership in getting epileptics back to work.

The first point is education. Since our attitude bars the epileptic from employment I recommend that the Federal Government provide funds for an epileptic education program and program developed in the following manner:

One, that the Secretary of Health, Education, and Welfare call an epileptic-in-industry conference by industrial leaders, that this conference be expanded to the State level and that this Government pro-

vide funds through the State offices of rehabilitation for the education of business leaders regarding the employability of epileptics.

Two, Workman's Compensation

Three, improving vocational rehabilitation techniques. Most people with epilepsy who require rehabilitation and placement are referred to their local office of vocational rehabilitation.

Thank you very much.

Mr. Elliott. Thank you, Mr. Simons.

(The formal statement of Mr. Simons follows:)

STATEMENT OF L. P. SIMONS, EXECUTIVE DIRECTOR, EPILEPSY CENTER, BOSTON, MASS.

Yesterday this committee heard Mrs. Albert Grass, president of the American Epilepsy Federation, discuss the problems of the epileptic child in school.

Today, I would like to discuss the epileptic in relation to employment.

Of the 1½ million epileptics in the United States, fully 80 percent can have their seizures eliminated or reduced to a minimum. Translated into terms of employment, this means that 80 percent, or over 1 million epileptics, properly placed, can be employed in competitive industry.

This is not to imply that a great many of the 15-percent group of epileptics who are not so well controlled cannot work, but, rather, that the 80 percent segment should present no problem to industry at all.

Unfortunately, being able to work does not mean that the epileptic can find a job. There are many industries that will not hire an epileptic even if he is completely controlled, let alone employ him if his attacks occur as infrequently as once or twice a year.

Loyalty to tried and trusted employees goes out the window when epilepsy is involved.

For example, we have the case of a man who was employed by a large insurance company for 7 years and was summarily fired when the company learned that he had had a seizure at home. The seizure resulted simply because the fellow had run out of medication.

Why does industry object to employing the epileptic? Employers offer the following reasons as to why they cannot hire epileptics:

1. The epileptic has a high industrial accident rate.
2. Workmen's compensation rates automatically rise when an epileptic is employed.
3. Epileptics have a high absentee rate.
4. Epileptics can perform very few jobs.
5. Other employees object to working with an epileptic.

Let us look at these objections and see how they stand up in the light of documented data.

Do epileptics have more industrial accidents than the nonimpaired worker?

As of 1958, according to the safety director of the Ford Motor Co. plant in Dearborn, Mich., there was not one accident worth noting, out of 165 workers, with epilepsy. Of course, seizures occurred, but they did not result in accidents.

A study by the U.S. Department of Labor in 1951 demonstrated that there is no significant difference between the disabling and nondisabling accident rate of epileptics and nonimpaired workers.

The Workmen's Compensation Board of the State of New York found that in the 8-year period, 1945-52, the average number of closed cases involving epileptics was only 10 out of 100,000.

In view of these facts it is evident that the epileptic worker is not an industrial accident risk. The attitude that he is, as held by industry, is completely without foundation.

Do workman's compensation rates automatically rise when an epileptic is hired?

In 1954, the Association of Casualty & Surety Cos. issued the following statement as regards workmen's compensation rates:

"Insurance rates are based on accidents involved in operation and the company's accident experience. No consideration is given whatsoever to the question of whether or not handicapped workers are employed."

Here again we can see that misinformation is hurting the epileptic in his search for employment.

Do epileptics have a higher absentee rate than the nonimpaired worker.

The 1951 U.S. Department of Labor study uncovered the interesting fact that the epileptic actually loses less time because of accidents than does the nonimpaired worker.

Further, the study showed that the work attendance records of epileptics were the same as for those on the nonimpaired worker.

Again, we have another meaningless argument.

Are epileptics limited as to the jobs that they can perform?

According to the pamphlet, "Patterns of Disease," published by Parke, Davis & Co. in 1958, epileptics were holding jobs in the following areas:

"Professional, business, and college students, 27 percent; clerical and skilled workers, 28 percent; sales and service workers, 20 percent; unskilled laborers, 25 percent."

From these statistics it can be seen that epileptics can handle jobs in every field of endeavor.

Do people object to working in close proximity to an epileptic?

Unfortunately, in some instances this is true, but it is not irrevocable. The Epilepsy Information Center has found that this problem can be solved when an employer will take time to interpret epilepsy to his employees.

The facts that I have just presented show conclusively that there is no valid reason why an epileptic who is completely or relatively free of attacks cannot be placed in competitive industry.

Further, the data indicates that the underlying reason the epileptic has difficulty with employment is not due to his physical condition, but, rather, due to the erroneous attitudes of industry toward him.

We cannot afford to allow these attitudes to continue indefinitely. Such attitudes are degrading and rob people with epilepsy of their dignity, they are causing a pool of potentially productive workers to be untapped.

From an economic point of view it is costing the taxpayers of this country a lot of money to support a group of people who are not working because of facts that were valid 100 years ago.

Since returning the epileptic to gainful employment is a national problem, I believe the Federal Government should become more active in this area. I would like to propose a three-point program which, if adopted by the Federal Government, would lead the way to acceptance of the epileptic by industry:

1. Education

Since outdated attitudes are barring the epileptic from employment, I would recommend that the Federal Government provide funds for an epileptic-in-industry educational program, and that the program be developed in the following manner:

A. That the Secretary of Health, Education, and Welfare call an epileptic-in-industry conference composed of industrial leaders throughout the Nation.

B. That this conference be expanded to the State level.

C. That the Federal Government provide funds through the State offices of vocational rehabilitation for the education of business leaders as regards the employability of epileptics.

2. Improving vocational rehabilitation techniques

Most people with epilepsy who require rehabilitation and placement are referred to their local office of vocational rehabilitation.

Unfortunately, because these units have large caseloads, and because of the difficulties in placement the epileptic is often overlooked or written off as not being suitable for rehabilitation.

To remedy this situation, I would recommend that the offices of vocational rehabilitation located in large urban centers establish within their organizations a division of epileptic services for a 5-year period. This special service devoted solely to epileptics would have its own counselor, social worker, and placement officer.

By establishing a division of epileptic services, I believe the following would be accomplished:

1. Rehabilitation services would be available to a more diversified group of epileptics.

2. A fund of knowledge about the employability of epileptics would be built up.

3. A concentrated effort to breaddown employer resistance to the epileptic would result.

4. Realistic standards for the employability of epileptics would be established.

Although there is a certain amount of resistance to establishing special services for special groups, I believe that the problems of the epileptic are so complicated that at least for a trial period of 5 years a program offering the epileptic specialized employment services is required.

3. *Prevocational counseling*

If the handicapped child is to develop into an economically productive adult he must have expert prevocational counseling by people who are familiar with the requirements of industry in this regard.

Also, the handicapped child must have counseling very early in his academic career.

I would, therefore, recommend that the Federal Government make additional funds available through the local offices of vocational rehabilitation for prevocational counseling of handicapped children and that this counseling be offered at the junior high school level.

In closing, I would like to say that money spent by the Federal Government in returning people to work comes back to the Government in the form of increased tax revenues.

I can think of no better source of new tax money than the 6 million handicapped people in America.

Mr. ELLIOTT. Our next witness is Mr. Oscar K. Weiner.

Is Mr. Weiner here.

Our next witness is Miss Frances Tappan.

Is Miss Tappan here.

Miss Tappan is the technical director of the School of Physical Therapy at the University of Connecticut.

STATEMENT OF FRANCES TAPPAN, TECHNICAL DIRECTOR, SCHOOL OF PHYSICAL THERAPY, UNIVERSITY OF CONNECTICUT

Miss TAPPAN. In the interest of gaining your complete attention, I have made my statement very short.

The Connecticut Chapter of the American Physical Therapy Association has asked me to speak to you concerning the educational aspects and in particular connection with the bill H.R. 3465 which is concerned with the most expedient rehabilitation of handicapped individuals.

Obviously, this care depends directly on the number and quality of therapists who can be educated to assume the immediate responsibility for this rehabilitation.

It is my particular responsibility as an educator to see that this education leads ultimately to the best possible method of physical rehabilitation.

Numbers at this point do not concern me as much as the quality of the therapists which we can graduate in our various schools. This quality depends directly upon the contemporary tools which are available for teaching purposes.

I am particularly concerned to find that, according to rehabilitation and training memo No. 60-5E, Department of Health, Education, and Welfare, under priorities for support places the specific project for development of teaching materials as its fourth priority.

The value of the three priorities which precede this cannot be denied for while it is indeed important to expand existing curriculums, encourage graduate study, and encourage specifically graduate education in physical therapy, it is even more important as I see it, to provide up-to-date, clear, and concise visual aids such as motion pictures, slides, charts, models, and printed materials to assure the fact that the therapists we do graduate are all well prepared to render the best patient care possible.

Other organizations and associations are doing a magnificent job with scholarships for these students, but there is also almost no other source other than the Office of Vocational Rehabilitation that will give us needed help to provide teaching materials.

I have made this point briefly and I hope strongly.

Anything you can do to strengthen this aspect of the program would, I am sure, contribute to physical therapy education throughout the country.

Thank you very much.

Mr. ELLIOTT. Thank you very much, Miss Tappan, for your testimony.

You have made a good point and have made it well.

Miss TAPPAN. Thank you.

Mr. ELLIOTT. Are there any questions.

Thank you, Miss Tappan.

Miss TAPPAN. Thank you Mr. Chairman.

Mr. ELLIOTT. Is Mr. Arthur L. DuBrow here?

Is Dr. Robcliff V. Jones here?

Mr. JONES. Yes, sir.

Mr. ELLIOTT. Mr. Jones is an associate in physical medicine and rehabilitation, assistant professor of medicine of Yale University.

We regret that we must impose a 10-minute limitation on you.

STATEMENT OF ROBCLIFF V. JONES, ASSOCIATE IN PHYSICAL MEDICINE AND REHABILITATION, ASSISTANT PROFESSOR OF MEDICINE, YALE UNIVERSITY

Dr. JONES. Rather than go over every point of the prepared statement I have, I would just like to bring out some major points.

Mr. ELLIOTT. After Dr. Jones has summarized her report, then the report will be made a part of the record, without objection.

Dr. JONES. First of all, I would like to express the appreciation of myself and all of us who are testifying here today and who were at the workshop in the last 2 days.

In regard to the needs for the New England area in rehabilitation, in special education, I think this will come out adequately from the workshop report that you will hear.

Inasmuch as we are concerned with individuals who have physical and mental handicaps and physical and mental impairments, we are concerned with individuals having specific medical problems.

Because of this, we are working with patients; and I think it is very important that we have adequate mental direction, supervision, and guidance in the planning of such legislation and in the implementation of this.

Now, as to where the facilities would be set up, or increased, I think this should be in no way limited to any particular group or place. But I do think that where it is possible we should use facilities having to do with medical schools.

The reason for this is that it would enable us to draw on a pool for future workers in the field, from young medical doctors and allied workers in the coprofessions that work in the medical centers, but I would like to repeat that this in no way means I feel this should be limited to any area like this, but it should be given consideration.

In regard to the independent living bills, 1119 and 3465, I think the goals of these are admirable and I am in entire accord with them.

One of the things that concerns me—and this in no way is a criticism of the bill; it is something that I think we should try to keep in mind when it comes to implement this—is that at present one of the major tests of successful rehabilitation is how many of the individuals that are working on this program are placed in a job.

Now, this extends the area of individuals being helped to a much larger group. I am apprehensive lest, say, the vocational counselor, who now has a larger number of patients to work with and individuals to work with, may not apply himself as vigorously toward the ones that are potentially employable.

I am merely transferring on to the vocational counselor what I have to do when I have a lot of work to do.

I try to cover it all and it is very difficult to make this final step, getting a job for the patient.

Mr. DANIELS. What do you recommend in this case?

Dr. JONES. All I can say is that this should be kept in consideration in every vocational counsellor's mind when he is working with them if it turns out the vocational counsellor will be the one utilized in carrying out this purpose.

Mr. DANIELS. Do you approve the idea of independent living under that bill?

Dr. JONES. I am sorry?

Mr. DANIELS. I say, do you approve the principle of developing the idea of independent living?

Dr. JONES. I certainly do. I am all for it.

But I think we should be careful not to fall into the pitfall that I can see occurring which I have just described.

In regard to specific points in the bills, I am a little apprehensive about having this all under one agency. I think this probably is necessary to make sure that we have an efficient program, but I am apprehensive that some of the very good groups that have a lot to offer might not be utilized as adequately as if this were dispersed through numerous areas.

I do not know the answer to this administrative problem.

Another point that concerns me some, and I must admit that I do not understand the wording on these particular parts adequately, is that in giving out the funds, say four times a year, if it comes out to be this, or twice a year, if there is some way that we could avoid the situation where, say, in June money may run out and patients have to wait until December before they can be taken on a program and then in December there is a lot of money, relatively a lot of money available, and suddenly everyone is looking for patients to utilize this.

I don't know whether this is a reflection of planning for future funds for the following year, or not.

I do not know how to overcome this, but I think it is something that should be taken into consideration so that we have a continuing amount of money without feast and famine, so to speak.

Those are the main points I would like to make, sir.

Mr. ELLIOTT. Thank you very much, Dr. Jones.

Did Mr. DuBrow come in?

Mr. DuBrow. Yes, sir.

Mr. ELLIOTT. Will you come around, please, Mr. DuBrow.

Mr. DuBrow is present of the Connecticut Rehabilitation Association.

I am sorry to say to you, Mr. DuBrow, we have to impose a limitation of 10 minutes.

Mr. DuBrow. I don't think I will take that long, sir.

Mr. ELLIOTT. You may proceed.

STATEMENT OF ARTHUR L. DuBROW, PRESIDENT, CONNECTICUT REHABILITATION ASSOCIATION

Mr. DuBrow. I would like to apologize for being late. I was informed by some people who participated yesterday that there was no need for me to rush since you were running pretty late yesterday. I took that as gospel.

Mr. ELLIOTT. We have speeded up a bit today.

Mr. DuBrow. The Connecticut Rehabilitation Association which I represent has a membership of well over 300 people in the State of Connecticut comprising both professional workers in the field of health, education, and welfare, and also numerous private citizens from all walks of life who are interested in and concerned with the problems of the handicapped.

The association has three points which we would like to present our viewpoints on.

The first of these is that we are a chapter in NRA as you well know, and we would like to go on record as definitely endorsing in principle the proposed legislation for independent living services.

However, the Connecticut association is concerned with some of the restrictive elements of the legislation in terms of proposing to make these services available to only two categories of handicapped people, those in institutions and those who are able to afford the luxury of an attendant.

From figures which we have been able to compile from the Connecticut State Department of Welfare, the Connecticut Bureau of Vocational Rehabilitation, and the Connecticut Society for Crippled Children and Adults, it looks as though there are something between 8,000 and 10,000 people in the State who are seriously disabled, who could profit from this kind of service, but who do not fall into these two categories of being in an institution or having an attendant.

Now, this number, of course, is being added to daily in terms of accident toll and illness and so on.

So this becomes a significant number of people for whom rehabilitation services on the State or Federal level are not available.

We are concerned about the possibility of providing some sort of service for this group of people.

The second point has to do with the acknowledged shortage of rehabilitation facilities. I think it is pretty well documented that nationwide there does exist a shortage of rehabilitation facilities.

However, the association feels it should be recognized that this situation does not pertain in all parts of the country and there are areas in the country where there are adequate rehabilitation facilities.

It should be noted that these rehabilitation facilities in many cases are not being utilized to their fullest maximum. The proposed legislation holds out the hope that Federal money will be available for building new facilities and for adding to existing facilities, and it is the association's hope that if the legislation is approved, in whatever form it may be, and that Federal money does become available that somebody take a good, long, hard look at the area where the money is going in terms of what the rehabilitation facilities are there and how much use is being made of these facilities before new Federal money is made available for construction of additional facilities.

I think this was our second concern.

The third point that we wanted to make concerned also the shortage, this time in the area of trained personnel. We feel that a good start has been made toward meeting the needs of shortages in terms of rehabilitation counsellors through the present programs in the various colleges and universities.

However, more and more of the other disciplines are becoming involved in the work of rehabilitation and it would be the association's hope that some provision be made for encouragement, scholarships, training for allied disciplines in terms of medical social workers, psychiatric social workers, psychologists, and other professionals who might be encouraged to enter into the field of rehabilitation and whose services are very badly needed and who are in very short supply.

These are the three major points which the association wanted to present and on behalf of the association I would like to thank the committee for the opportunity of presenting these viewpoints.

Thank you very much.

Mr. Elliott. Thank you, Mr. DuBrow.

Without objection, the the witness' statement will be made a part of the record immediately following the gentleman's oral statement.

Mr. DuBrow. Thank you.

(The statement referred to follows:)

STATEMENT SUBMITTED BY ARTHUR L. DUBROW, PRESIDENT, CONNECTICUT REHABILITATION ASSOCIATION

The Connecticut Rehabilitation Association, which I represent, comprises a membership of more than 300 people in the State of Connecticut. These members are both professional workers in the fields of health, education, and welfare, and also private citizens from all walks of life who are interested and concerned with the problems of the handicapped.

The Connecticut Rehabilitation Association would like to go on record as heartily endorsing the proposed legislation to provide independent living services. However, the association is concerned with the restrictive elements of this legislation which proposes to make these services available only to those individuals in institutions or to those who have an attendant present. From figures compiled from the State dept. of welfare, the State bureau of rehabilitation, and the Connecticut Society for Crippled Children and Adults, it would

appear that there are between 8,000 and 10,000 disabled persons in this State who do not fall into either of these two categories. These disabled individuals who are not in institutions and who do not have an attendant are just as much in need of independent living services as the two groups specified in the proposed legislation. The daily toll of accidents and disease is constantly adding large numbers to this latter group.

It has been well documented, that nationwide, there is a shortage of rehabilitation facilities. However, the association feels that it should be recognized, that in many parts of the country, adequate rehabilitation facilities do exist. It should be likewise recognized that many of these existing facilities are not being utilized to their fullest capacity. Therefore, the association would like to recommend that, before Federal funds are made available to any area for the addition of or the construction of new rehabilitation facilities, steps be taken to insure the fullest use of existing facilities and a request for Federal funds intended for new facilities be fully justified and substantiated.

The Connecticut Rehabilitation Association is also concerned with shortages in the area of trained personnel. It is felt that excellent progress is being made in terms of meeting the needs where rehabilitation counselors are concerned. However, it is now evident that other disciplines are becoming more involved in the process of rehabilitation and the association feels that some provisions should be made for assistance to prospective medical social workers, psychiatric social workers, psychologists, and other professional workers who are willing and anxious to devote their efforts in the field of rehabilitation.

On behalf of the association, I would like to thank the committee for the opportunity of presenting the viewpoints of the organization.

Mr. ELLIOTT. Has Mr. Oscar Weiner come in yet?

I notice that Mr. Stanley Myers is here. He is scheduled to testify in behalf of the Parents and Friends of the Mentally Retarded Children of Bridgeport, Conn.

Mr. Myers, will you come around and give us the benefit of your testimony?

We are very happy to have you, sir.

STATEMENT OF STANLEY MYERS, ON BEHALF OF PARENTS AND FRIENDS OF MENTALLY RETARDED CHILDREN, BRIDGEPORT, CONN.

Mr. MYERS. It is a pleasure to be here, sir.

Honorable Chairman, ladies and gentlemen, members of the committee, in 1956 a station wagon stopped at the house of a 24-year-old girl. There is nothing different about this normally; this happens every day in our lives where handsome young men stop at 24-year-old girls' homes and take them out dancing, dining, and to the movies.

Unfortunately, in this case we have a little different situation. This 24-year-old girl was being taken out for the first time in her life by another man. She had never been out of the house before in the company of anyone else other than her mother or her father, or probably both.

She could not walk. She could not talk. She could not go to the bathroom by herself. She could not feed herself.

But for the first time in her life she was leaving a home to go to "school."

I must put the school in quotes. This girl was picked up by a driver and carried to a station wagon and placed in that station wagon and taken to a center in Bridgeport and cared for there for a period of a short 3½ hours.

For the first time in 24 years this girl smiled at someone else. For the first time in the family's life they had an opportunity to go out together without worrying whether the child was adequately cared for. I cannot measure this in terms of money or in terms of material benefits to anyone. I can only measure it in terms of what it means to a family to have hope and something for a child who is presently remaining at home.

Now, granted you can say, "Why should not this adult be placed in an institution?"

We don't have the right to make that decision. This remains with the parent to make this decision. But at the same time, even if this 24-year-old girl was to be institutionalized in our State alone because she is mentally retarded, there would be a 3- to 5-year waiting period.

During that period must we deny this individual an opportunity to progress?

When I am asked why you keep bringing this child in, why don't you force these parents into institutionalizing this child, I can only give one answer: "She smiles," and for this reason every penny that is spent on this child is worth it.

The same thing applies to a 7-year-old or a 9-year-old who is inadmissible to public school training because they are mentally retarded. There is a bill presently before the Congress and I probably am getting off the point here, but a parent in Norwalk comes to me and says, "I came to this country from Hungary, out of Austria. All my family was admitted to this country except my 13-year-old mongoloid boy who cannot come because he is mentally retarded."

This has been the history of the problem of the retarded for practically forever. The problem now faces us, I think, and we as society must face this problem and examine our own conscience.

Toward this end the Parents and Friends of Mentally Retarded Children of Bridgeport, a parent-sponsored organization, has endeavored to create services for the retarded children and adults in the community, where the problem, we feel, must be met in the eventual final analysis.

Toward this end we feel that the Federal Government can stimulate the local organizations, the State organizations, who can benefit these individuals, can stimulate them in helping to meet the needs of these individuals. To this end we feel that a number of things could be done.

No. 1, we feel that there is to our knowledge no specialist in the field of mental retardation on a national level. The Office of Vocational Rehabilitation, which takes a great interest in this problem, does not have anyone specifically delegated to the problem of the retarded.

The States do not have anyone specifically delegated to the problem of the retarded. Direct grants to workshops have been provided. We feel they should be extended on teaching grants which should be granted for purposes of providing services we feel are needed of the specialists in vocational placement for retarded should be provided.

In the Office of Vocational Rehabilitation in the U.S. Employment Service areas; added services in vocational rehabilitation in State training schools should be provided.

Through the Federal Government we feel that the vocational educational of the retarded should be investigated and expanded in the direct grants to State trade schools.

School work programs are being investigated now where adults go to school for a 3-hour period and work for a 3-hour period. These should be further investigated.

Grants for subtrainable adults in sheltered workshops: We know what they cannot do generally. We are not so sure as to what they can do. This, we feel we must find out.

In the area of special education, preparation of teachers for subtrainable children, children who have been diagnosed as mentally retarded by one individual or perhaps by other individuals, and perhaps there is a misdiagnosis—perhaps we should look into this more closely so that the subtrainable, as he is so classified, is not stigmatized for the rest of his life as a subtrainer without opportunity to improve the capacity that he presently has.

Research into some more effective teaching of teachers; speech training for retarded: At present it is most difficult to get speech education for mentally retarded children presently participating in public school programs.

Grants for competent clinical psychologist and social workers in public school systems, with medical consultants available all for the purpose of differential diagnosis.

The possibility of reimbursement grants for recreational programs for school-age children. Staff personnel in the Federal Government in education for correlation and standardization of days and curriculum for training.

Grants to personnel in State offices of education to work more closely with local boards of education.

There are many problems that exist in this field and many areas which we can investigate for purposes of benefitting a tremendous segment of the population which formerly has had little concern expressed over the needs and the desires of these individuals.

I appreciate being here. Thank you for the opportunity.

Mr. ELLIOTT. Thank you, Mr. Myers.

Mr. GIAIMO. Mr. Myers, is part of this difficulty in the field of mental retardation in our State the fact that we have waiting lists in our training schools and so forth, the fact that there is not a sufficient amount of public awareness or concern?

Mr. MYERS. As you probably know, the last Legislature of the State of Connecticut has recognized the problem and passed a series of bills which we trust will make the public more aware of the problem, as well as provide services to the retarded, and we feel on a community level. Although there is a waiting list of 3 to 5 years in the State training schools, I am of the personal opinion would never be able to build the State schools to house the potential number.

As an example, last year the number of live births in the Greater New Haven area—Bridgeport, Derby, Milford—there were 15,000 live births. If we estimate conservatively 1 percent of the population being mentally retarded, that gives you an indication of just the number we must care for as of last year. Compounding that with this year's births, this gives you an idea of the potential we must recognize.

Mr. GIAIMO. The difficulty I see in this whole field of mental retardation is that there seems to be a shortage of facilities, funds, and training personnel; is that not true?

Mr. MYERS. Yes.

Mr. GIAIMO. Is that not the reason for this primarily, the fact that until there is sufficient public recognition of this problem so that then the States and local governments and perhaps the Federal Government will become aware of it, until such time it is very questionable whether we are going to get the trained personnel and facilities?

Mr. MYERS. This is true, but we feel there is another problem involved, too. We must not only get the public aware of the problem, we must get the parent aware of the problem, the professional aware of the problem.

We have heard for a number of years that we do not have sufficient teachers in the field of mental retardation. We also do not have sufficient classes in the field of mental retardation.

This is a vicious circle which will never end. If you don't have the classroom you will never find the teacher. If you don't have the teacher you will never get the classroom.

It is true, we need a great deal more public awareness of the problem. At the same time, unless the start is made, we can never make the public aware of what the need is.

If I may extend this just one moment, I personally feel that if we are in a position to start small, which has happened in the State of Connecticut, we then can build from that point. But if we are not in a position to start at all, it is a question as to whether we will ever start.

Mr. GIAIMO. One of the questions that will be thrown at this committee in Congress at such time any recommendation will be made to furnish assistance to mental retardation, one of the first questions will be thrown at us as to why do not the States do more about it? What is the answer to that?

Mr. MYERS. Let me put it this way: I will put it on a local level.

You gentlemen were kind enough to visit a center yesterday that started on a local level without one penny's aid from the Federal Government, or from the State government. It was all done through community awareness of the problem, community support of the problem.

If we can present the problem to the community in such a way as to inform them of the need, if we can eventually find a number of children whom we suspect are mentally retarded, the State of Connecticut conducted an investigation in 1957 where they estimate that there are approximately 40,000 known mentally retarded children and adults in the State of Connecticut alone. It is projected to about 2 percent of the population.

These are known figures. So the problem has to be brought out into the open, No. 1.

No. 2, once it is brought out in the open, if we don't meet it at that level, then we are back to where we started from.

Mr. GIAIMO. Thank you.

Mr. DANIELS. Mr. Myers, what do you estimate the mentally retarded population of the United States to be?

Mr. MYERS. The national statistics claim 3 percent of the population is mentally retarded. Our own feeling is that if this is true,

roughly 2 percent of the population is retarded, who will need some assistance in supervision as far as living in a community is concerned.

One percent is that borderline level that perhaps we will never get to see. They get jobs and adjust to the community and move in the regular society.

Mr. DANIELS. As I have been listening to the witnesses that have been testifying here, we have a pretty sick Nation, 10 million disabled housewives, 8 million speech and hearing defectives, 1½ million epileptics.

You just gave me a figure of 5 million mentally retarded. This is only part of the field.

Mr. MYERS. It is a matter of degree, if I may say so, Congressman. No. 1, the individuals about whom you are speaking are individuals who perhaps can be cured or who perhaps can subsist on a normal level.

We are talking about a segment of the population who will never be cured. We have so little research in the area to find the reasons. Presently today we know approximately 77 different reasons for mental retardation. I can quote you four which have been investigated recently that we think we can control.

We don't know yet, because it is so recent we don't have enough proof to say it can be controlled.

So the area of research has to be looked into more fully.

Mr. DANIELS. With such an alarming number of people who are ailing in one manner or form or another, do you think there would be a greater awareness of the problem nationally and that something would have been done about it prior to this date—

Mr. MYERS. I would think so, but I have never been able to figure out why it has not happened.

Mr. DANIELS. Fortunately, our committee under the chairmanship of Mr. Elliott, is endeavoring to do something about it.

Mr. MYERS. Thank you.

Mr. ELLIOTT. Thank you very much, Mr. Myers.

Now, has Mr. Weiner arrived yet?

Mr. Weiner, we have restricted our witness today to 10 minutes. If you have a longer statement than that and you want to summarize it, I am happy to say to you that the complete statement will be made a part of the record.

You may proceed, in view of that limitation, in any manner you care to.

STATEMENT OF OSCAR D. WEINER, EXECUTIVE DIRECTOR, CHILDREN'S CENTER, HAMDEN, CONN.

Mr. WEINER. I am representing here the Children's Center which is a private association located in Hamden.

I would like to speak from the point of view of opportunities through the rehabilitation acts that might be considered by the Federal Congress to augment the treatment and study of emotionally disturbed children who are residents at our institutions.

These children have not been able to meet the demands of living as a member of the family. We feel that at our agency we have the ability and the potential to structure treatment and to give appro-

pritate services to these children except in the area of schooling which has become increasingly difficult.

There are now 72 children in residence. Some of these may benefit by keeping their ties with the community, by attending public schools in New Haven.

However, it has been found by both the school faculty and by our staff that many of these children need special classroom services, preferably located at the institution where they can be more individually supervised by our teachers in small groups.

The incidence of school maladjustment as a major reason for referrals to our institution is increasing at an alarming rate.

Whereas 2 years ago about one-third of our referrals were children who had repeated major difficulties in public schools, now almost three-quarters of our referrals emphasize this.

These children come to us after moving from one temporary home to another and from school to school, having had little opportunity to develop trusting relationships, confidence, incentive or skills so that they might achieve some learning.

Out of our 72 children we have 18 in 2 special classrooms at our institution. Both we and the very cooperative local public school people feel that this simple environment for a temporary period is absolutely necessary during the treatment of these children before they go into the more complex public school system and especially in the secondary schools where they must go from classroom to classroom, from teacher to teacher, without the benefit of constant and consistent supervision.

There are, in addition, 16 of our children who at this moment desperately need special classroom help.

We and the public school authorities feel it is a pity that these children and many on our waiting list, cannot be provided with this special service.

It seems too vast a problem for the local board of education to handle.

However, it would appear to be of such benefit for agencies such as ours who have made a tremendous investigation, to meet these emotional problems to be able to complete our job by assistance in building up school facilities to meet the increasing educational and vocational problems referred to us.

We have evidence that the children who have been in these two specialized classrooms have profited from this experience. They have adapted to special classroom routines where they have been constantly observed and could not be tempted to leave.

We have had boys who have openly defied and threatened to assault the various public school teachers who now have a chance to know one teacher and through that relationship to develop trust.

Our two teachers have felt that in small classrooms they have been able to ferret out interests and talents in pretty inadequate students which the public schools do not have the time to do.

These children have gained enough confidence to try a little in other areas where they have previously felt inadequate.

We have countless children in these classrooms who were at one point incapable of staying in public schools, but later were able to return to public schools and adjust.

Our children have had severe emotional problems and poor educational background and incentive before they came to us. Although we wholeheartedly endorse high standard vocational schools and services with the broad scope of academic as well as practical courses, we find also a very urgent unmet need for supplementary vocational services for those children who have been handicapped, but must go out in the community after 16 years of age and earn a living.

We would, therefore, like to see funds for vocational training provided for treatment institutions.

We endorse the development of independent living workshops or rehabilitation services for handicapped persons over 16 years of age, referred to in bills 1119 and 3465.

We would also hope that residential facilities may be considered as important for these youngsters so that they might serve those gains which they might receive from these rehabilitative services through a situation which is both supportive and strengthening to them.

Our urgent question is not the growing need of special vocational and educational services for emotionally handicapped children so vast that it is beyond the resources of the local board of education and perhaps beyond the State capacity to finance unless Federal assistance is available, perhaps through a matching formula, that encourages State and local communities to take initial steps with at least token investment of their funds.

In summary, we give testimony to the need for additional special classrooms for the emotionally handicapped to the end that study and treatment services be rounded out with proper treatment, geared in education.

Two, we give testimony to the need for vocational schools geared to the practical goal of preparing children with lesser academic competence to learn a trade which will enable them to become self-supporting.

Three, we endorse independent living facilities for the handicapped with the suggestion that supportive group residences be provided in order to preserve the gains of these rehabilitative services.

Thank you very much.

Mr. ELLIOTT. Thank you very much.

Mr. GIAIMO. May I ask one question?

Mr. ELLIOTT. Mr. Giaimo.

Mr. GIAIMO. Is your school supported by public or private funds?

Mr. WEINER. It is a private agency.

Mr. GIAIMO. It gets no support from the State at all, does it?

Mr. WEINER. The support it gets from the State is through partial payment for board. In no case does any parent or State government through the State welfare department pay the full cost of care.

Mr. GIAIMO. Thank you.

Mr. ELLIOTT. Thank you, Mr. Weiner.

If none of our afternoon witnesses are here, we will adjourn until 1:30.

May I ask those of you who are here to cooperate with us in passing the word around to any possible witnesses that we are trying to finish by 4 o'clock this afternoon.

We have witnesses scheduled through 4:50, but if we can get word to those that we are speeding up our schedule a little bit, I think they will cooperate with us.

(Thereupon, at 12:10 p.m., the subcommittee was recessed, to reconvene at 1:30 p.m., same day.)

AFTERNOON SESSION

The subcommittee reconvened at 1:30 p.m., upon the expiration of the recess.

Mr. ELLIOTT. The subcommittee will be in order.

Somebody said that a "North wind doth blow and we shall have snow" and I am hoping that you will pardon me if I tell you I have in mind to seek the sunnier climes beginning about 4 o'clock.

First, I am going to recognize the Honorable Anthony C. Gelormino, mayor of Torrington, Conn.

Mr. Gelormino, will you come around.

He tells me he can make his statement very short and he needs to be somewhere else very badly and we will recognize him at this time.

STATEMENT OF HON. ANTHONY C. GELORMINO, MAYOR OF THE CITY OF TORRINGTON, CONN.

Mayor GELORMINO. Thank you, Mr. Chairman.

Mr. Chairman, members of your committee, I would just like to go on record as being in favor of your legislative bills to help the handicapped and unfortunate people of the country.

I would like to tell you just a little about Torrington. About a year and a half ago I appointed a committee on rehabilitation and aid to the handicapped. This committee consists of prime members of individual agencies, including State unemployment, our welfare department, directorate of health, and the various agencies which are doing their very best to aid the handicapped.

Also in the city of Torrington I do have a little bit of school, we call it a school, to help the exceptional children. They are primarily mentally retarded children and also various handicaps.

We are going to place another teacher on that who is being specially trained to conduct the courses in the school.

To date my committee on aid to the handicapped and rehabilitation is working very closely with the State rehabilitation centers. We have found in a survey recently that we have about 90 people that are in dire need of such type services.

We also find that with the knowledge of the residents of our area that such a committee does exist, that many people are coming out of obscurity and people who have been tucked away in homes for many, many years are coming out and registering with the hopes that they may be able to be helped.

I am very happy to report that we have made some progress. We are doing everything we possibly can to help these unfortunate people.

I was rather amused and amazed this morning when one of your colleagues questioned one of the people here who gave testimony, that we have a real unhealthy country with the multiples of people who are afflicted.

I do feel that what you are attempting to do will certainly eliminate a lot of that because there is certainly a lot of overlap.

Many of the different agencies have the same people on their records. I think there is mass duplication. That is the reason for my committee. We are a city with a population of just over 30,000 people. To date we have about half of 1 percent.

We are an industrial city. In addition to trying to rehabilitate and to aid these people, I have members of the committee, members of management and labor and chambers of commerce, so that we are also able after due evaluation and all the aid that can possibly be

given to make an attempt to find the handicapped person employment.

I sincerely urge the Congress of the United States to give favorable consideration to enactment of the proper type of legislation which will assist the communities and the towns and the States and the entire country.

We do need assistance. As yet we have not used tax dollars. If there is need for it I intend to budgetize a minimum amount and work from there, but I want to sincerely urge you to do everything you possibly can to get the proper legislation passed which will enable these unfortunate people to smile again and to live with dignity and independence and certainly to assist the domestic problems in their families so that they will not carry the cross alone.

My sincere thanks to all of you for the pleasure of being here and also my own personal congratulations to Congressman Giaimo for his effort to bring the committee here. I hope you will get enough evidence and information here to indicate that there is a dire need for that type of legislation.

Thank you, sir.

Mr. ELLIOTT. Thank you very much, Mayor Gelormino.

Now, Dr. Pasquale Confreda.

Dr. Confreda, we must limit you to not more than 10 minutes.

STATEMENT OF PASQUALE CONFREDA, PRESIDENT, PARENTS LEAGUE, RHODE ISLAND SCHOOL FOR DEAF, PROVIDENCE, R.I.

Mr. CONFREDA. Thank you for reminding me, but I think I can speed up the time. I have about 3 minutes.

Mr. Chairman, members of the committee, as president of the Parents League of Rhode Island School for the Deaf, and father of six children, two of whom are deaf, I wish to approve the recommendations made to the committee.

I wish to commend highly the work of Senator Lister Hill in introducing into the Senate Joint Resolution 127 and Representative John E. Fogarty for his work on companion bill 488 introduced in the House, and to the others who have worked for this important cause.

The teachers that I have known who have taught are dedicated to their work and it is miraculous the result they obtain under such difficult odds.

I am in favor of any grants-in-aid program to encourage more teachers to become speech and hearing therapists. The children in our country who are handicapped by deafness need the skill of specially trained teachers of the deaf to develop their ability.

We also need specially trained speech pathologists and audiologists to help those with speech and hearing impairment.

I endorse on behalf of myself and the Parents League of Rhode Island School for the Deaf, which I am representing, anything which may further this goal.

Thank you for the invitation to appear and speak to you.

Mr. ELLIOTT. Thank you very much, Dr. Confreda.

Is Mr. Victor Reis here?

Mr. Victor Reis is the chairman of the Rehabilitation Commission of Torrington, Conn.

Will you come forward, sir.
You may proceed.

**STATEMENT OF VICTOR REIS, CHAIRMAN, REHABILITATION
COMMISSION OF TORRINGTON, CONN.**

Mr. REIS. Thank you, Mr. Chairman.

I merely wish to state briefly that I would like to concur in the statement made by Mayor Gelormino so far as the city of Torrington is concerned. He covered it very, very adequately.

I just want to add that there is definitely a need for special rehabilitation and education here in the State of Connecticut. I not only speak personally of my own personal experience. For 11 years I conducted the program for the Veterans' Administration concerning prosthetic and sensory aids. I am very well acquainted with the dire needs that are presently quite obvious.

And not to take up too much of your time, as Mayor Gelormino indicated, we in the city of Torrington are definitely making an attempt to do our share for the purpose of rehabilitating these individuals that are in dire need of this particular type of training.

I at least hope that when you do return to Washington that a special effort will be made to enact the proper type of legislation which the entire country will be very proud of.

Thank you.

Mr. ELLIOTT. Thank you very much, Mr. Reis.

Our next witness is Mrs. Douglas T. Wilson, president of the Rhode Island Congress of Parents and Teachers.

Mrs. Wilson, you have heard me speaking of the time limitations, have you not.

Mrs. WILSON. I promise to abide by the rule.

**STATEMENT OF MRS. DOUGLAS T. WILSON, PRESIDENT, RHODE
ISLAND CONGRESS OF PARENTS AND TEACHERS**

Mrs. WILSON. I am Mrs. Douglas T. Wilson, president of the Rhode Island Congress of Parents and Teachers.

We welcome this opportunity to speak of some of the unmet needs in Rhode Island in the field of special education. The division of the State department of education that deals with special education is working constantly to improve these services in the public schools. However, throughout the work with the mentally and physically handicapped, and the gifted, there emerges a pattern of similar needs.

It is this pattern of unmet needs which the Rhode Island congress wishes to bring to the attention of the subcommittee.

1. All teachers should be trained to recognize problems: For any child to receive the benefits of existing special education programs it is necessary that his individual needs be recognized. The classroom teacher if trained to spot symptoms of trouble, is the logical person to set the wheels in motion to secure for the child the help he needs.

This applies to poor eyesight, poor hearing, and emotional disturbances. All of these difficulties are much more successfully treated if

detected early. The child's education may proceed and he remains a happy member of the community.

2. More teachers are needed in special education: Many more teachers are needed in all fields of special education. More teachers of the mentally retarded are needed. Some communities are having difficulty complying with the State law requiring instruction of the educable and trainable, because of the problem of transporting these children. If more teachers were available these communities might have smaller neighborhood classes nearer the homes of these children. Likewise more teachers are needed for children with partial vision.

There is need for more speech therapists in Rhode Island. It is estimated that the three thousand pupils assisted by speech therapy in the past year are only about half of those who need it, and there are undoubtedly many more whose need has not been recognized.

This past year about 14 school districts in Rhode Island have had some form of special program for gifted children. These communities are now beginning to feel the need for more teachers specially trained in this field.

3. Early evaluation, treatment, and follow-up of problems: In most Rhode Island communities a social worker is called to go to the home only when a problem interferes with attendance in school or disrupts a class. By that time the problem is far advanced.

Along with the need for teachers who are trained to recognize problems some program is needed to work with the home, to help parents understand and be impressed with the need for early treatment.

This points out a need for more school social workers. The role of such personnel in helping the child, the teachers, and his parents to understand his difficulty and to bring about changes necessary to correct the situation, should have more emphasis. The social worker's skill and experience can be valuable in assuring early treatment.

In the case of emotionally disturbed children, there is a need for follow-up care if the benefits derived from existing clinics are to be permanent.

The clinic staff is unable to follow these children into the home and the community. Lack of funds to provide sufficient resources for getting and keeping these children under effective care creates additional problems for the school and the community. House Joint Resolution 488, training teachers of the deaf, and pathologists and audiologists.

Policy No. 4 of the legislation program of the National Congress of Parents and Teachers states, in part:

Federal funds appropriated for education should be available for special programs for the education of handicapped children.

The Rhode Island Congress of Parents and Teachers favors the passage of House Joint Resolution No. 488.

There are at present 23 speech and hearing therapists working in the public schools in Rhode Island. It is estimated that a minimum of 50 additional ones are needed.

There are at present no facilities in Rhode Island for training speech pathologists and audiologists. While it might be desirable to establish such a training center in Rhode Island, we are aware that large expenditures for an extensive faculty and teaching equipment would be required.

If facilities in nearby States are not being used to capacity, our needs may be filled by encouraging enrollment of more Rhode Island residents in these centers.

If this bill passes, it is hoped that the existence of the fellowships that will be established will be widely publicized so that Rhode Island residents might hear of them and apply. Regarding H.R. 1119 and 3465, The Rhode Island Congress of Parents and Teachers favors H.R. 1119, independent living. In so doing, we are furthering the action program of the National Congress of Parents and Teachers which is concerned with the prevention.

In this case it is the prevention of institutional care for those handicapped persons who may be restored to independent living.

The Rhode Island congress favors the provision of this bill which removes the restriction that a person must be progressing to employability before the vocational rehabilitation program can be applied.

Progress of an individual as far as becoming self-sufficient at home and thus able to stay out of an institution is in itself desirable. And this is economically sound.

In Rhode Island we are in the midst of a \$10 million expansion program at the Ladd School for retarded children. It is estimated that unless we can help the adult mentally and physically handicapped to independence we will be faced with the expenditure of another \$20 to \$30 million for institutions for their care.

Further, it may well be that the workshop plan as a preemployment experience will assist many more handicapped persons to progress to employability than at present.

Thank you again for this invitation to present our views here.

Mr. ELLIOTT. Thank you very much, Mrs. Wilson for a very fine statement.

Is Dr. Josephine Rathbone here.

Miss RATHBONE. Yes, sir.

Mr. ELLIOTT. Dr. Rathbone, is formerly director of recreation in rehabilitation, Teachers College, Columbia University.

You may proceed.

STATEMENT OF JOSEPHINE RATHBONE, FORMERLY DIRECTOR OF RECREATION IN REHABILITATION, TEACHERS COLLEGE, COLUMBIA UNIVERSITY

Dr. RATHBONE. Gentlemen, today it is my great pleasure to present the Consulting Service on Recreation for the Ill and the Handicapped of the National Recreation Association.

We are not here to quarrel with any concept enunciated in bill H.R. 3465, except possibly the implication that grants shall be forthcoming only when assurance has been given that the facility or program is "feasible and necessary for vocational rehabilitation"—page 6, section 203(a) (1) and page 17, line 20, even outside the competitive labor market, page 15, line 17.

We see independent living as meaning something different from vocational self-sufficiency, for many severely handicapped and older persons, page 2, lines 3 and 4.

We see at least the last three of the "four Fs," food, family, friendship, and freedom, for handicapped individuals as for you and me, depending on much more than economic or vocational sufficiency.

We believe that the social sufficiency of the individual is of prime importance in our democratic society.

If Mrs. Beatrice H. Hill, the director of the Consulting Service on Recreation for the Ill and the Handicapped, of the National Recreation Association, were here, she would stress the need, among the chronically ill, and handicapped, for social communication and food for the mind as well as the body.

I share with her, of course, a realization that, however, vocational self-sufficiency is to be one of the aims of all of us committed to expanding and improving what Dr. Howard Rusk first called "the third phase of medicine, rehabilitation."

Mrs. Hill might tell you the story of Jimmy Seaborn. The year is 1949. The boy, Jimmy, is 18 years old. The diagnosis is rheumatoid arthritis, affecting the entire spine, the vocational rehabilitation is rating zero. The rehabilitation team can do nothing more for him. He is to spend his life in a chronic hospital.

Today, 10 years later, Jimmy, unable to either walk or sit, limited in movement to a slow motion shuffle on crutches, or free movement on a self-propelled stretcher, is a full time recreation leader at the prevailing wage scale in the St. Joseph's Home for the Aged in Peoria, Ill., 1,000 miles from the hospital which for so many years was his home.

How did this come to be? A miracle, perhaps? No. The answer to Jimmy Seaborn and his triumph over a crippling handicap was motivation through social rehabilitation.

In short, developing in him a driving need to function to the fullest degree possible within the limitations of his handicap, and the knowledge and skills necessary to satisfy the need.

Ten years ago Jimmy, on the verge of melancholia, with little or no contact with people beyond his own ward, was discovered by the recreation therapist of the hospital. The first step in the development of James Seaborn, recreation leader, was taken when he was persuaded to join the patients' glee club. In a short while he was the glee club director. Then reporter on the patients' newspaper. In time, its editor.

So it went over the years with constant encouragement, motivation education in recreation theory and skills, and participation in dramatics, arts and crafts, the hospital's interroom radio station, in short; all the activities which make up a well-rounded program of recreational activities for the chronically ill and handicapped, as well as for you and me.

Today this boy, who cannot sit in a chair, who can only move with the greatest difficulty, directs a complete recreation program in a home for the aged, recruits and trains volunteer aides, and motivates the aged patients of the home toward the social communication which is necessary if the home is to be a community in the true sense of the word, and not just a place in which to wait for death.

This is an example of the values of recreational therapy, as a tool in helping to motivate the seriously handicapped to the point where

whatever potential is left is susceptible of vocational rehabilitation or independence.

We in the recreation profession want to question, not what can be done in the rehabilitation of the chronically ill and handicapped, but what is not being done for them, especially here in New England.

We, representing the National Recreation Association, must point out that we are not qualified to present problems in special education out that we are not qualified to present problems in special education, but we do know the Jimmy Seaborns of the United States and make a plea for their needs for socialization and activities which lend to psychophysical rehabilitation.

This all has a flavor thoroughly congenial to special education.

I must assure you, also, that many of the registered recreation personnel providing recreation for ill and handicapped in this Nation are college graduates in education, and members of the AAHPER, a division of this National Education Association.

It would be useless, here in New England, for me to go before any State or municipal body and any hospital board or any council of social agencies, requesting funds for an expansion of their rehabilitation services, if I carried with me only statistics about the number of hospitals in the Nation that do or do not have professionally directed programs of recreation, or the number of proprietary nursing homes for the aged without adequate programs of socializing activities for those likely to become or to remain vocationally self-sufficient or the paucity of playgrounds that can safely service handicapped children.

I would be asked to make a survey locally. This is what will support local fund raising in New England. Fortunately, such a procedure is envisioned in section 205(a)(1) of HR 3465.

I feel sure that the States of New England can be expected to abide by the Federal-State regulations as to financing laid down in the bill under consideration.

There are some strikingly good progress of total rehabilitation in New England to inspire extended local efforts, I draw to your attention:

The Institute for living, in Hartford;

Crotched Mountain Rehabilitation Center in New Hampshire;

The Liberty Mutual Insurance Co.'s program initiated in Boston, to say nothing of fine programs in individual hospitals in that area, and research within the Department of Medicine at the University of Vermont in Burlington.

I am not purposely leaving out Maine, where such excellent total care for children with orthopedic limitations was in operation 40 years ago in Portland. Or the special research in Providence, R.I., regarding allergic reactions in relation to psychological stress, to be conquered with the help of relaxing techniques.

We must not forget, either, the excellent departments of special services and of physical medicine rehabilitation in the VA hospitals of this district.

But the programs, with the exception of the VA, have all been independent efforts of physicians and other interested parties, struggling for funds with which to serve a very few individuals.

They have known how important is independent living for the individual and for the society of which he has to be a part. They give the kind of demonstrations needed in New England to inspire total rehabilitation.

Since I have been here the past few days, these doctors and others have known how important it is. This would mean activity centers, consultation centers for the homebound, proper services in the nursing homes, homes for the aged, and other agencies where the program today means nothing more than nursing care in bed.

But where are the funds within this bill?

What we need, in the profession and the agency I represent today, is funds for scholarships and training grants, and to make demonstrations and to disseminate information as to the studies and investigations, which have already been conducted to help the many Jimmy Seabornes become independent, psychologically if not completely physically.

Bill H.R. 3465 can make all this possible. We want to provide more and better programs, with better trained personnel, for the purposes of cultivating and sustaining morale, of providing enjoyable and enriching experiences and increasing each handicapped individual's opportunities for social expression.

Without social communication, the end result of recreational therapy, there can be no independent living.

Thank you.

Mr. ELLIOTT. Thank you very, very much, Dr. Rathbone. You have really challenged our thinking in this field and we appreciate it.

Is Michael F. Walsh, commissioner of education of the Rhode Island Department of Education, here?

Mr. Walsh, because of many factors we have had to impose a rather strict time limitation this afternoon of 10 minutes.

You may proceed, sir.

STATEMENT OF MICHAEL F. WALSH, COMMISSIONER OF EDUCATION, RHODE ISLAND DEPARTMENT OF EDUCATION

Mr. WALSH. Mr. Chairman, members of the committee, as commissioner of education of the State of Rhode Island, first of all I would like to express my deep appreciation for the invitation to be here to express our views, and commend you, Mr. Chairman, and your committee, for the excellent work you are doing in this particular field of rehabilitation of the handicapped child as well as for all educational purposes.

We from Rhode Island actually are pro-Fogarty—

Mr. ELLIOTT. I am pro-Fogarty, too.

Mr. GIAIMO. I am, too, for the record.

Mr. WALSH. What we are particularly concerned about is the interest you have expressed in your committee for the welfare of our young people as well as our adults.

We wholeheartedly subscribe and support these bills that pertain to the paying of teachers for speech and hearing as well as broadening the base of rehabilitation so that we can incorporate those people who up to now have been disenfranchised, we might say, from developing

the qualities they might have developed had the opportunity been presented to them.

We believe that the operation must be broadened and the Federal Government must take a stronger part in financing programs in cooperation with the States.

It should be a cooperative movement and shared with the States and the Federal Government in order that no young person in this country, no American citizen is denied an opportunity to grow to the full extent of his mental, social, and physical ability.

An act of God is an act of God. The only thing we can do is to live with it and by the grace of God make the adjustments as we see the adjustments to be made among our fellow men.

I believe that the Federal Government will have to do something to impress upon the minds of future colleges and divisions of colleges and education that every teacher who is prepared to go out in the field of teaching should know all the handicaps that a child possesses.

In my humble opinion I am convinced that the more we know about the handicapped and what their problems are, the better are we able, ourselves, to teach the normal child.

The more that we bring up children in the atmosphere of normalcy the better the child is and the emotional disturbances at home are reduced to a minimum.

Furthermore, about 80 percent of the children who are handicapped could be taken care of in normal classrooms provided the teachers had been given proper training in their undergraduate years and given an opportunity for graduate work and then, which is vitally important, and I am quite sure it must be in the mind of your committee, that assistance be given to these teachers when they are in the classroom, psychological testing, medical assistance, and social assistance, for the simple reason that one never begins to realize how well a blind person can take care of himself or herself until one has lived with a blind person and seen what a blind person can do.

The same with the retarded. If we are to educate the American people to the importance of this field of the handicapped we have to bring in the normal people every day living with the handicapped to realize what the handicaps are and to see how well they can take care of themselves in spite of handicaps.

Now, I think that in providing the teachers with these skills and opportunities and clinics, that we can take care of a great many of these young people in our normal classroom work.

Mr. Chairman, I would strongly advocate two very important factors as I see it that are unmet:

The need for every prospective teacher of a class in the handicapped, the emotional, medical, and physical and to make provisions that when these teachers are out in the classrooms that they get the professional assistance needed to help them to be able to direct and guide these youngsters who sit before them.

This means early identification of all our children. And this early identification of their problems must be kept record of and led into this matter of rehabilitation because there is no distinction between rehabilitation and what we are talking about in the handicapped child.

That rehabilitation must get down deep in the life of the child and begin to have a record made of these conditions and a file kept so that when the child approaches 14 years of age there should be a complete record, and rehabilitation counselors should be working in the high schools and schools to help direct the work of these youngsters in the anticipation of picking them up someday.

For that reason we believe that early identification of problems is necessary, that guidance and counseling must be provided in these services for our teachers and materials and professional employers.

Then we can pick up those who are able to go to work and can help those who are unable to work because I think, as one speaker has previously said, we owe some consideration to these people who are homebound and whose mind can become affected if we do not do something to keep their time occupied.

I would ask you, Mr. Chairman, also, to give serious consideration to the possible use of television in developing a stronger and broader program in the field of rehabilitation, particularly for our adult people, because I think those who are homebound, if a sound program can be developed, they can be greatly helped through the utilization of good TV programs.

Mr. Chairman, I am deeply grateful to you for the time you have allowed me. I trust that you will continue your energy to present these bills to Congress and see that they are properly enacted because I think you are making a tremendous contribution to the morale of our country and I know of no time, Mr. Chairman, when the morale of this country needs to be bolstered up so much as it is right now.

Thank you.

Mr. ELLIOT. Mr. Giaimo.

Mr. GIAIMO. I am very interested in the comments you just made about the possible use of the TV in homebound rehabilitation.

Do you have in your department any information on projected courses on that that you could send to us?

Mr. WALSH. No, sir; all we have is a fairly good visual-aids department.

Mr. GIAIMO. I was interested in TV. I think you have hit upon something.

Mr. WALSH. We do not.

If I may have just a moment to tell you, we did make application a couple of years ago for the utilization of TV, but it was for the mentally retarded. We thought we might be able to take a class of mentally retarded and film them, you see, and then utilize that for discussion periods because we feel that something has to be done to get the parents of these mentally retarded children in a place where they can go to these diagnostic centers and have their frustrations eliminated. That goes back to the early identification of the child.

Mr. GIAIMO. If you have any information and send it to us, we will appreciate it.

Mr. WALSH. Thank you.

Mr. ELLIOTT. Thank you, Mr. Walsh.

Dr. William A. Fraenkel, consultant to National Association for Retarded Children, Committee on Vocational Rehabilitation, and Sheltered Workshops.

Dr. Fraenkel, we are happy to have you. You understand the time limitation.

STATEMENT OF WILLIAM A. FRAENKEL, CONSULTANT TO NATIONAL ASSOCIATION FOR RETARDED CHILDREN, COMMITTEE ON VOCATIONAL REHABILITATION AND SHELTERED WORKSHOPS

Dr. FRAENKEL. Yes; I do. Mr. Chairman and members of the committee, I am pleased to be here on behalf of the National Association for Retarded Children.

I am happy to submit the evidence you have in front of you now for the record, and with your permission highlight the three charts as the gist of the entire presentation.

Mr. ELLIOTT. Without objection, the statement which Dr. Fraenkel has filed will be made a part of the record.

(The statement referred to follows:)

TESTIMONY OF WILLIAM A. FRAENKEL, PH. D., CONSULTANT ON VOCATIONAL REHABILITATION AND SHELTERED WORKSHOPS NATIONAL ASSOCIATION FOR RETARDED CHILDREN, INC.

The National Association for Retarded Children is pleased to offer its support of the Rehabilitation Act of 1959 on behalf of 5 million retarded children and adults in this country. This testimony will present some background information on who we are, the group we represent, and will describe those of our activities germane to the topic. We will point out how this act would enable vital services which are currently unavoidable to be provided for the adult retarded in this country.

WHO IS NARC?

The primary purpose of the National Association for Retarded Children, Inc. is to improve the welfare of retarded persons through counseling for the family; special education and training; vocational training; integration into society; and training personnel. Current research efforts are directed toward prevention.

The National Association for Retarded Children, Inc., known as NARC, is the only national voluntary, parent-inspired association devoted exclusively to an aggressive, united attack on the problems of mental retardation.

There are 700 affiliated local and State units. Included in this figure are units in Hawaii, Puerto Rico, and in military installations abroad. Generally, NARC broadens public awareness of problems of mental retardation. Specifically, it provides local units with consultation and guidance to improve their services and gain sufficient support.

WHOM DO WE REPRESENT?

There is substantial agreement that about 3 percent of the population, or 5 million children and adults, are mentally retarded to the point of requiring specific services or facilities either throughout their lifetimes or at crucial periods. These services or facilities may involve no more than the provision of special classes in the school system for the upper group of retardates, or permanent nursing or infirmary care for the most severe cases.

In recent years it has been found practicable to divide the total number of retardates into the dependent, the semidependent and the marginally independent groups.

One person out of every thousand of the total population, or one-tenth of 1 percent, belong in the dependent group, requiring hour-by-hour supervision. As adults they do not go beyond a mental age of 3 years (and many do not go that far). Many of them have severe physical handicaps, are unable to walk or to talk; must be fed and clothed. Yet, even in this group some individuals have responded to training along minimum social lines, and these efforts, when successful, decrease the need for personal care and enrich the individual's

human existence to the point that he can learn to walk, take care of his bodily needs and dress and feed himself.

Four persons out of every thousand population fall into the middle group of semidependents. Even the upper brackets of this group develop at less than half the rate of normal children, yet many have capabilities for learning self-care, patterns of acceptable social behavior, and performance of useful work. Where these trainable children are given an opportunity to enroll in well-conducted, well-staffed classes, important advances have been achieved.

About $2\frac{1}{2}$ percent of the population, or 25 out of each thousand people, are found in the marginal independent group. As children they are considered educable, but sufficiently retarded to require attendance at special classes. Most of them can utilize some vocational guidance and training, and many eventually become at least partially self-supporting adults, capable of managing their own affairs, but they will need counseling in periods of stress and crisis.

In order to obtain a clear picture of the kind of assistance that has been offered to the mentally retarded person to help prepare him for his contribution to himself, his own family, and to society at large, we need to review briefly two necessary areas in his life development—education and training.

EDUCATION

The problem of mental retardation has probably existed since the beginning of man. In the United States the first institutions were organized in Massachusetts and New York about 1850. It was believed at that time the organization of institutions was the solution to the problem. The second development, about 50 years later in 1896, was the establishment of special classes for the educable mentally retarded. Both of these developments have been extended to practically all of the 48 States.¹ Both kinds of organizations—institutions and public school classes for the educable mentally retarded—are still expanding since they have been unable to meet the demands placed upon them.

Fifty years later, around 1950, we find a third development, the organization of community classes for severely retarded or trainable children, primarily under public school auspices. This third development points up the fact that institutions and public school classes for educable children are not sufficient, and that other provisions are necessary. The efforts of parents to retain their retarded children at home and find community provisions for them has resulted in the organization of classes for trainable children in 18 States.

But the organization of classes for trainable children in communities is not going to solve the problems of all parents who wish to retain their children at home. There will be many others for which provisions are not available. Who is responsible for the preschool severely retarded child in the home? What provisions will be made for him? Since schools admit only school-age children, will the provisions be day-care centers or classes under a welfare agency? Who is responsible for the severely retarded adult at home? Is the sheltered workshop the answer? And who is responsible for the custodial child if the parents refuse to send him to an institution? Who is responsible for the diagnosis and for parent counseling?" (1)

TRAINING

The history of the State-Federal program of vocational rehabilitation in this country dates back to 1920 when the National Civilian Vocational Rehabilitation Act was enacted.

This original act did not provide services for the mentally retarded. With the passage in 1943, of Public Law 113, which became popularly known as the Barden-La Follette amendments, the mentally retarded were included for the first time among those to be provided with rehabilitation services.

"Prior to 1943, the major emphasis in vocational rehabilitation was on training and placement. Medical aspects of rehabilitation, the psychological impact of the disability, counseling, and interviewing, intensive use of community resources—all these accepted tools of vocational rehabilitation today, were not recognized as basic to vocational rehabilitation until the passage of the Barden-La Follette Act." (2)

¹ This report was written prior to Alaska and Hawaii statehood.

The following services are provided throughout the Nation:

- (1) Thorough physical examination;
- (2) Necessary medical, surgical, psychiatric, and hospital services;
- (3) Necessary prosthetic devices, such as artificial limbs, hearing aids, trusses, and the like;
- (4) Individual counseling and guidance;
- (5) Training for a job in schools, on the job, by correspondence or by tutor or related;
- (6) Maintenance and transportation during rehabilitation, if necessary;
- (7) Necessary tools, equipment, and licenses;
- (8) Placement on the right job;
- (9) Followup to make sure the worker and the job are properly matched.

In 1954, "Executive hearings were conducted by the House Committee on Education and Labor and open hearings by the Senate Committee on Labor and Public Welfare. The result was the passage of Public Law 565 of the 83d Congress, which was signed by President Eisenhower on August 3, 1954." (3)

NONPROFIT WORKSHOPS

Under Public Law 565, otherwise known as the Vocational Rehabilitation Amendments of 1954, the vocational rehabilitation program was greatly expanded through a three-part grant structure, making grants available for (1) support of basic State vocational rehabilitation programs; (2) extension and improvement of rehabilitation services; and (3) support of special projects.

This legislation gave impetus to the growth and development of expanded and improved vocational rehabilitation services for the mentally retarded. Sheltered workshops emerged as a new resource in the total effort to rehabilitate the potentially employable mentally retarded.

The National Association for Retarded Children reported in 1959 on a nationwide survey it conducted on 56 member units of the NARC Operating Sheltered Workshops for the Mentally Retarded in 1956-57. (4)

The majority of such programs serve those retardates "who have a reasonable employment potential" through the utilization of the workshop program of service. The three major services rendered by most sheltered workshops include: (1) vocational evaluation; (2) adjustment and vocational training; (3) remunerative employment.

The last report from the office of Vocational Rehabilitation (1958) states that 1,600 mental retardates were rehabilitated for gainful employment as contrasted with 1,094 in the previous year.

It has been estimated some 250,000 adult mentally retarded can profit from a sheltered workshop experience. (5) The need for national facilities of this type are obvious when one compares the number of retardates being rehabilitated annually as of today.

Title III of the Rehabilitation Act of 1959—"Workshops and Rehabilitation Facilities"—would provide for additional facilities of this type.

However, our nationwide workshop experiences reveal that the mentally retarded separate out into four groupings within such vocational rehabilitation training programs;

GROUP DESCRIPTION

Group A: Those retardates able to be successfully placed into competitive employment at the end of their sheltered workshop training.

Group B: Those retardates able to maintain productive roles within the sheltered workshops.

Group C: Those retardates unable to maintain consistent productivity within the sheltered workshop.

Group D: Those retardates unable to meet sheltered workshop standards. Those retardates in groups C and D require a different type program to meet their needs. Then there are, in addition, a number of severely retarded currently unable to gain admission into sheltered workshops.

INDEPENDENT LIVING CENTERS

In order to serve those retardates in groups C and D as well as those unable to enter into sheltered workshop programs, additional adult programs are required. These retardates will require such programs in the areas of personal and social

development which will enable them to become more self-sufficient and self-reliant.

Title II of the Rehabilitation Act of 1959—"Independent Rehabilitation Services"—would establish a program of rehabilitation, constructed in this broader sense. It would enable adult retardates, able to do so, to leave an institution and to achieve such degree of independent living as to dispense with the need for institutional care. It would enable those adult retardates who are homebound to enter into independent living rehabilitation programs thereby largely dispensing with the need for their being attended at home.

If we as a nation are to take advantage of the proposed "independent living" legislation, it becomes imperative that we begin to think now and plan ahead for new facilities and new services for our country's severely retarded adults. Special programs will be required for those unable to become remuneratively employed within the sheltered workshops. New programs will need to place a greater emphasis on an individual's ability to function and to participate within the home, the community and within an adult activity which need not be vocational in nature. "There is a need to make a life rather than a livin". (6)

"For more than 10 years the spotlight in rehabilitation has been on the person with a disability and the team immediately surrounding him. Now the focus should broaden to emphasize the everyday life of the disabled person, his home, community, and the society in which he lives, if we are to insure for him a satisfying and productive existence". (7)

As necessary as institutionalization may be for some retardates ("about 150,000 persons were in such public institutions at the end of 1957") (8), there is widespread agreement that those able to remain at home and in the community should be enabled to do so.

Saenger (9) in a comprehensive study of 2,640 severely retarded adults reported that two-thirds "were found to be living in the community * * * A major part of this study was concerned with the home adjustment of the severely retarded. Most had made a good adjustment; one in four participated in everyday family life, took an active interest in the affairs of other family members, and tried to help within the limitations of their ability. About one-half were able to communicate in a limited way with other family members."

Improved medical care, better dietary management, wholesome activities and work opportunities all seem to contribute to a substantial lengthening of the lifespan of the retarded. Hence it is of the utmost importance to plan now for the anticipated presence in communities of a substantially larger number of older retardates, through hostels and other residential facilities, vocational opportunities, recreational outlets and appropriate counseling resources.

"I propose that the retarded have the same right as anyone else to be at home and to remain in their communities. This concept implies that, whenever possible, we must minimize the differences between their mode of living and that of others. The greater the likelihood for the retarded to remain with his own family during his childhood, and in his own community as at least a partially contributing member during his adult life, the fuller his life will be. If we agree on this principle, then we must admit that his separation from his family or his community is likely to be a sign of failure, either on his part or on the part of those responsible for his care." (10)

Certainly there is no comparison to the cost involved in providing independent living rehabilitation services to the costs of institutionalization. When one reviews the cost of institutionalization "The average maintenance expenditure per patient (in 1957) was \$1,279.67." (11)

Though there are no accurate figures on the costs of building new institutions, a few costs of recent buildings might be helpful to indicate what part of these costs are—

(1) Arkansas Children's Colony-----	\$1, 080, 000
(2) Denton, Tex. (being built)-----	2, 750, 000
(3) State School, Butner, N.C.-----	6, 343, 000
(4) Selingsgrove, Pa.-----	8, 000, 000

No one of the above facilities serves more than 1,200 patients.

As Miss Mary Switzer, Director, Office of Vocational Rehabilitation has stated: "For every dollar spent on vocational rehabilitation we can expect a return to society of \$10 in taxes." (12)

Appropriations for the Rehabilitation Act of 1959 are recommended as \$10 million for the first year; \$12,500,000 for the second; and \$15 million for the third.

Why should the National Association for Retarded Children, Inc., discuss institutionalization costs in presenting testimony on a rehabilitation bill? Unfortunately, the group of retardates who would benefit most from the Rehabilitation Act of 1959 (the semidependents—see p. 1 of this report) are, in most cases under current vocational practices (Public Law 565) unable to receive any services whatsoever. Past experience with our adult retarded population clearly shows what occurs when no services are made available in the community. As a result these retardates are either kept at home, left to look out of a window as the world goes by with television (if available) as their major source of enjoyment (13) or else, they are institutionalized.

One of the key provisions of the Rehabilitation Act of 1959 is title IV—"Rehabilitation Evaluation Services," "The term 'rehabilitation evaluation services' means (1) diagnostic and related services (including transportation) incidental to the determination of the nature and extent of an individual's physical and mental impairment and rehabilitation potentials and the rehabilitation services required to realize these potentials, (2) the determination of appropriate referral of such individual for vocational rehabilitation services as defined in title I of this act, independent living services as defined in title II of this act, or other needed services provided by public or private agencies." (14)

Under the present laws, State rehabilitation agencies could conceivably provide this service to applicants for vocational rehabilitation, but have shown themselves reluctant to do so when the prognosis appears to be something less than vocational rehabilitation.

Many people believe that the weakest element in present vocational rehabilitation programs is that evaluation. The National Association for Retarded Children feels that the need for effective evaluation services would be intensified, if the States accepted responsibility for the rehabilitation of persons who would not be required to have vocational potential at the time of application. If this title becomes effective, it is believed that it will accomplish more than any other one thing could do to systemize and bring order into rehabilitation activities, assuring that no one is denied at least an adequate evaluation. It would furthermore, centralize in one place, under one agency, evaluation services for all adults.

Vocational Rehabilitation Services should be greatly improved, particularly for the severely retarded. It should no longer be required that the agency decide in the beginning whether the handicapped individual can be vocationally rehabilitated. This will result in the acceptance for services of many retardates who otherwise would have been rejected, without being given an opportunity to actually demonstrate their potentials.

It is logical to assume that there will be a number of retardates who will be able to progress from an institutional or home setting to a life in the community. These retardates may even make a partial contribution and some will make a full contribution to their families, themselves, and to society through either sheltered employment or full-time employment.

Whether we call the mentally retarded subnormal or deficient; whether their disability is mild, moderate, or severe; whether they are capable of being dependent, semidependent or semiindependent; extremely retarded, trainable, or educable, unless we provide for their needs, account for their individual differences and recognize that they like all of us, function on different levels at home and in our society at large; then we will further retard their development and deny them the opportunity to make contribution, not only to their families, to the total social effort but to themselves as individuals. And it is this right, once provided, that will again affirm what is essential and unique in our American way of life.

In speaking about the physically handicapped in the publication, "The Handicapped and Their Rehabilitation" Hoerner says: "Through a functional activities treatment program, it has been demonstrated that the individual's physical and mental reserve potential (his safety factor) capabilities can be brought forth and that eventual adjustment of total or partial physical and vocational independence can be achieved. Functional training directed toward four major objectives have been grouped under the term 'activities of daily living':

- (1) Maximum use of the hands in all self-care.
- (2) Ability to travel about.
- (3) Adequate speech.
- (4) Normal, near normal or good cosmetic appearance." (15)

This above quotation describes training objectives in rehabilitation which excludes the mentally retarded. Are the retarded without the need to learn how to use their hands effectively, productively? Do they not need to travel about? Are they not able to use speech? Should they not be as normal looking as possible?

The counterpart program for the mentally retarded which would provide for activities of daily living is called personal adjustment training. A working definition of personal adjustment training might well be "Personnel adjustment training is the process of providing social, emotional, personal, spiritual, and physical experiences for the mentally retarded as a necessary step toward their living independently in society."

The program physical demands of daily life as developed by the Institute for Crippled and Disabled in New York (16) could be adapted so that the needs of the mentally retarded were properly recognized. It could become an integral part of the personal adjustment training program with one major difference. Instead of providing instruction and training toward employment preparation, the initial emphasis would be instead on both home adjustment and community participation.

By providing for developmental experiences in the area of fundamental home skills (meal preparation, dishwashing, care of clothes, bedmaking, room care, local travel, and other self-care activities) a foundation is laid for family relationships, home responsibilities, and independent living.

Additional graded experiences and opportunities for everyday social activities, proper use of leisure time, avocational skill development, interpersonal relationships, and personal need fulfillment pave the way for good health habits, individual adjustment, and community participation.

In some instances, as a byproduct of these independent living rehabilitation activities those retardates able to progress and partake of sheltered workshop programs will be better prepared for such vocational training programs. Because of their participation and sharing in home responsibilities and community activities, they will be more wholesome well-rounded individuals. Their personality development will be reflected by the gains they make through successful personal, social, and interpersonal relationships.

In all instances, the severely retarded will be able to live a more fruitful, less dependent life thereby becoming less of a burden to themselves, their families, and society. Such an undertaking of this type is in keeping with our democratic way of life and is in the public interest.

The Rehabilitation Act of 1959 will enable a considerable number of the mentally retarded to become rehabilitated. Too often the end of education for our severely retardates has resulted in a return to their homes or institutionalization. Our hopes lie in this act which will provide so much help to those who need others so that they can help themselves.

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Dr. FRAENKEL. To begin with, my job with the national association is to travel around the country and help member units set up programs for the adults.

So my remarks will have to be only for the adults and rehabilitation.

We feel that it is necessary to have steps to rehabilitation for those who need it and a preliminary step will be a comprehensive evaluation of the individuals, emotions, personal, medical, education, and so forth, adjustment and current status.

From that point on we would be able through independent living on account for his need for self-care, dressing, undressing, toileting, feeding, taking care of his personal needs which would lead into presocial kinds of activities within the home which in turn would move into what we call activity centers which are actually prevocational and would enable these retarded who can move into this kind of program to achieve a social development.

From that point on, to move into prevocational to the vocational.

As we all know, the sheltered workshop offers vocational evaluation, adjustment training, and employment for those who have to remain in the workshop and for those who go into community employment, outside placement.

So there is this continuity of program.

We feel there would be on the whole much more done for their rehabilitation.

The next chart is mainly to indicate the relationship between a program and the individual's home independence and his community adjustment. If we take the three programs again and try to see the person functioning in the home and in the community we have a good idea as to where he should be in the program.

For example, somebody who is able to function 50 percent of the time independently at home and can participate 50 percent of the time in the community would not be expected to function properly in the vocational rehabilitation and sheltered workshop.

If he is here he is misplaced. He should be in the activity center program or, better yet, in an independent living program where his needs can be met to the point where he can lift himself up above the bootstrap and move across the area of adjustment.

The same way for somebody who is able to function three-fourths of the time independently at home and function in the community, he would not expect to be in an independent living center.

By the way, these charts are handmade so I apologize if they are not too clear.

The third, of course, brings up the problem of the home. That is what is going on in the New England region.

The top figure shows the latest statistics on population in the New England area. It is close to 10 million people.

Of that we projected 3 percent of that population as being mentally retarded, which would be approximately 300,000.

Within the State of Maine there are to our knowledge one or two programs only for the adult in rehabilitation. This is beyond education.

In New Hampshire we have no record of any adult program for the mentally retarded.

I am sure there are some, but we have no information on them.

In the State of Vermont they have a Rutland rehabilitation center which is a halfway house and training agencies for those who move out of the institution and back into the community.

They also have a sheltered workshop.

In Massachusetts there are programs in Salem, Williamstown, Boston, and Springfield, according to our information.

The most recent has been a grant given to Boston to set up a research project for the retarded in employment.

The same thing has happened in Rhode Island. They have recently acquired a research grant which would enable the program in Providence to take a group of retarded and try to find out where they can be properly placed in community employment.

In Connecticut there are programs in Stamford, Hartford, Greenwich, Bridgeport, and Waterbury.

Our records show less than 25 programs.

We would say as a conservative estimate that there is a need to handle at least 15,000 retarded adults in these kinds of programs.

Twenty-five programs or less, as a modest figure, are unable to account for more than 2,000 at best. This gives you an idea as to need.

As far as what can be done, I believe the bill that is being discussed, 3465, would enable the majority of these programs to be increased and certainly we are very much in favor of title II, the independent living services, which would provide for those retarded, who are at this moment perhaps at home or some who are in institutions, to be able to live a more dignified life and perhaps move out of the institutional setting into the home and in some instances into the workshop and in some instances into employment.

This is very, very possible.

So we feel that this is a bill that would be the counterpart to the Barden-La Follette Act of 1953. This would enable the next group who are unable to move into employment to be properly taken care of.

It would eliminate the term "vocational rehabilitation." It would make it rehabilitation.

Mr. ELLIOTT. Thank you very much.

Mr. FRAENKEL. Thank you, sir.

Mr. ELLIOTT. Our next witness is Edmund S. McLaughlin, executive director, United Cerebral Palsy, Fairfield County, Conn.

Is Mr. McLaughlin here?

If Mr. McLaughlin is not here I will call our next witness, Dr. Ralph F. Garry, Boston University School of Education, Boston, Mass.

In his absence I will call D. Reinhardsen, Jr., first selectman, Town of Guilford, Conn.

STATEMENT OF D. REINHARDSEN, JR., FIRST SELECTMAN, TOWN OF GUILFORD, CONN.

Mr. REINHARDSEN. Mr. Chairman, gentlemen of the subcommittee, this afternoon I must attempt to wear four hats at the same time and to concur with your desire of getting to sunnier climates.

I will attempt to do this the best I can.

I have the pleasure and privilege of representing the Connecticut Association for Retarded Children as vice president of that association.

Further, to represent a local organization known as the Shoreline Association for Retarded Children as president of that organization.

Thirdly, as first selectman of the town of Guilford, a community of some 8,000, and fourthly, as parent of a mentally retarded boy, aged 7.

In deference to your desires, Mr. Chairman, I will paraphrase the statement that we have prepared for today's presentation and present this for your consideration at the conclusion of my remarks.

I first would be remiss not to sincerely extend our thanks, the thanks of the parents of retarded children, the thanks of the Connecticut association, and the thanks of the children themselves for the efforts, considerations, and the work that your committee has so far so nobly done in your attempt to shed light on the problems that exist and to bring the handicapped children of our Nation closer to the goal of opportunity and the self-fulfillment for Americans regardless of their condition or their limitations.

We are also extremely grateful to our own Connecticut General Assembly who in this past session enacted what may well be the most comprehensive body of State legislation ever adopted in this field within a single year.

Of course, the keystone of this legislation was the creation, as you probably are well aware, of a division of mental retardation within the existing State department of health.

The various divisions of this bill are too numerous to mention in any detail. The establishment of sheltered workshops so desperately needed are one phase.

A phase that I am particularly interested in, however, is our day care program. The day care programs have mushroomed throughout this State in the past 5 years. There is no question of their need or the fact that with more extensive day care facilities that fewer children, even those of the severely retarded category, may not have to be institutionalized.

A great deal of emotional pain could thus be spared the children themselves and their parents and the cost of institutional facilities and services in our opinion could be reduced substantially.

Day care classes, though still in their infancy in Connecticut, and probably elsewhere throughout the Nation, have already demonstrated that they can do a great deal to bring the retardate out of his shell to overcome many emotional obstacles and to start the child on the road to good social adjustment.

The day care class certainly represents as much an educational process to the day care child as the trainable class to the trainable child.

And does this not suggest, Mr. Chairman, that the educational role of Federal agencies under your committee's jurisdiction should be

broadened to include day-care programs provided that they, of course incorporate training elements and are not merely custodial.

A great deal could be contributed in this area by Federal agencies. There is, for example, no such thing anywhere in the Nation to our knowledge of a formal training program for day-care instructors. There are no manuals on methods or on techniques.

Very few conferences or seminars have been planned to be held. No body of philosophical theory covers this increasingly important area.

Yet the number actually of potential day-care retardates no doubt exceeds the total number of children in certain other groups of the handicapped who are very fortunately already enjoying some of the betterments under Federal programs.

Today, December 18, there are 300 children born mentally retarded. Tomorrow, December 19, 300 more will be born.

By the end of the year, 120,000 will be added to the rolls of the already 5 million that now exist in this country today.

We are not talking about isolated cases. It is one of our major problems.

Another important legislative enactment of our Connecticut Legislature in this past year was the institution of mandatory education. Here, as first selectman of a growing community, I am well aware of the problem that this presents.

The stimulus of your legislation, sponsored by your committee, has been an important factor in swelling the ranks of teachers of the retarded which is going to become one of the most important problems as this act becomes law in September 1961.

The Office of Education and other Federal agencies can make a very important contribution to the solution of teacher training, teacher recruitment, curriculum, and innumerable other problems, with which Connecticut and most of the other States are faced in meeting the need of the retarded.

And one particular education area which will take on an increasingly important role starting in 1961 will be that which includes the groups between the ages of 16 and 21.

As you are well aware, the practice of most school systems throughout the country has been to drop retardates when they reach the age of 16.

Connecticut's new law means that not only will these young people remain in school, but that new programs must be devised so that they, the schools, and the communities, will receive the maximum possible benefit from their lengthened school years.

Like many other States, Connecticut has major curriculum and program needs in the fields of this age group and we sincerely look to the Federal Government for leadership in stimulating new and better approaches and techniques.

The problem of retardation, I believe, has come out of the closet. I would like to include in the statement I will turn over to you a copy of a local weekly paper of one of our community towns, the town of Guilford. To show you what small communities are thinking with respect to this problem, I would like to quote very briefly part of an editorial which I will submit in full:

There are some difficulties which can strike without regard to financial, intellectual, social or physical status of a family and for which science has as yet discovered no preventative procedure. They can produce an intolerable continuing load on a family in ordinary circumstances. This, in turn, can eventually lead to an increase in the public burden. There are countless degrees of retardation. In many instances proper education can make useful citizens out of youngsters who without special attention might never achieve an effective life. This kind of education is specialized, time consuming, and therefore, comparatively costly. Yet besides being of tremendous importance from the humanitarian point of view, it is generally justifiable economically because of the extent to which it reduces the cost which the individuals involved might ultimately impose upon the family and upon society.

Mr. Chairman and gentlemen of the committee, I sincerely appreciate your attention, your consideration of all that you have heard over the past few days. I sincerely trust that you will carry back to your full committee those comments with assurance that through your efforts we will realize the ultimate achievements that many of these children can achieve through these efforts.

Thank you very much.

Mr. ELLIOTT. Mr. Giaimo has a question.

Mr. GIAIMO. I just want to say thank you, Mr. Reinhardsen, for coming. I am aware of the interest you have in this program.

Just recently I visited the town of Guilford. I noticed a project you have there, I believe you are interested in it, for the mentally retarded children.

What was the name of that?

Mr. REINHARDSEN. You mean the Thrift Shop?

Mr. GIAIMO. Yes.

Mr. REINHARDSEN. This is one way of raising money.

Mr. GIAIMO. Is that not the idea on a community basis, on a voluntary basis?

Mr. REINHARDSEN. All the money raised to support our program—I am speaking now of the community of 8,000—is through voluntary contributions through community funds, through cake sales, rummage sales, and so on, and through this community thrift shop.

There has been no State money, no public money used to carry on the program that exists in our community and this is true throughout the State, and I am sure throughout the Nation.

Mr. GIAIMO. Thank you very much for coming down.

Mr. REINHARDSEN. Thank you, sir, again.

Mr. ELLIOTT. Thank you, Mr. Reinhardsen.

(The documents referred to follow :)

[Editorial from the Shore Line Times, Guilford, Conn.]

FOR HUMANITY AND ECONOMICS

There are some difficulties which can strike without regard to financial, intellectual, social or physical status of a family; and for which science has yet discovered no preventive procedure. They can produce an intolerable continuing load upon a family in ordinary circumstances. This in turn can eventually lead to an increase in the public burden.

Retardation is a problem of this nature. Guilford and its neighboring towns have assumed a position of leadership in meeting it. The Shoreline Association for Retarded Children has made tremendous progress during its comparatively short history, and is one of the most effective units in the State group with which it is associated.

There are countless degrees of retardation. In many instances proper education can make useful citizens out of youngsters who without special attention might never achieve an effective life. This kind of education is specialized, time consuming, and, therefore, comparatively costly. Yet besides being of tremendous importance from the humanitarian point of view, it is generally justifiable economically because of the extent to which it reduces the cost which the individuals involved might ultimately impose upon the family and society.

The existence of a local, active, friendly organization and school for the exceptional child, moreover, makes it easier for the parents to recognize that the difficulty exists and to take the necessary steps to meet it.

Any way one looks at it, SLARC is a community asset. It has found so much need for its services in this and neighboring towns that its budget has had to expand continuously to keep pace with the demands upon it. We urge the townspeople to grasp the opportunities they have to help it—community fund, thrift shop, and projects sponsored by various service clubs.

STATEMENT BY D. REINHARDSEN, JR.

Mr. Chairman, gentlemen of the subcommittee, in behalf of the Connecticut Association for Retarded Children, I extend heartfelt thanks to you—thanks for permitting our association to present its views to you, but more especially for the great impetus you have already given to the advancement of special education and rehabilitation for the retarded, and for your continuing efforts—as manifested in your current hearings—to bring the handicapped of our Nation closer to the goal of opportunity and self-fulfillment for all Americans, regardless of their condition or limitations.

Dr. Elizabeth Boggs, president, and Dr. Gunnar Dybwad, executive director of our National Association for Retarded Children, have already presented to you the broad views of the NARC in the special areas with which your committee is concerned. We of the Connecticut ARC wholeheartedly endorse these statements.

I believe the time you have so generously allotted our State association can most profitably be used in, first, summarizing the content and aims of the legislative program adopted this year by the Connecticut Legislature at our request, and, second, pointing to certain implications which flow from this legislation.

The Connecticut General Assembly this year enacted what may well be the most comprehensive body of State legislation ever adopted in this field in a single year. The specific bills were the result of many years' experience and study by both the organized parents and friends of the retarded and professional workers allied with them.

The keystone of this monumental legislative program was the creation of a division on mental retardation within the State department of health. The division is to be administered by a deputy commissioner of health, with the guidance of an advisory council on mental retardation, consisting of seven persons with backgrounds in this or related fields. The division has jurisdiction over all State-sponsored programs for the retarded except for education and rehabilitation, and will make allocations of funds in three areas where appropriations were made for the first time in 1959.

Education and rehabilitation remain in the domain of the State department of education, but as you can appreciate, a new State agency dedicated to the stimulation of new and expanded programs for the retarded of all ages and conditions, and armed with subsidies to encourage the development and growth of local programs, cannot help but have an important influence on education and rehabilitation as well as other aspects of the mental-retardation problem.

Moreover, in the rehabilitation field, while the State rehabilitation agency is limited to counseling, testing, dissemination of information and other supportive functions as well as administration of training funds on an individual basis, the new State program provides for grants of operating funds to workshops as such—including workshops both for retardates judged capable of rehabilitation under existing standards, and those judged incapable.

The State of Connecticut thus takes a broader view of which retarded persons warrant governmental assistance, both in their training and, if circumstances require, in their continuance in sheltered workshops. Implicit also in the new State legislation is the belief that many retardates who cannot qualify for the present Federal-State rehabilitation program can be helped.

There is a significant number who may never attain a State of independent living, or even marginal independence, and yet may become considerably less dependent on their families and communities as a result of workshop training—even if that training is on a minimal level. This in itself would warrant operation of special workshops for this group. Even more important is the fact that fine lines between categories of the retarded cannot be drawn—that the retardate classified as custodial today might very well become a promising workshop participant or even a worker in private industry next year, given the proper training, guidance, encouragement, and, if indicated, emotional nourishment.

Prior to the passage of this State statute, only one full-fledged workshop for the retarded was in operation in Connecticut. Our State association is hopeful that the new legislation will stimulate establishment of such workshops in every part of the State.

Another phase of Connecticut's 1959 legislation for the retarded provides for State guidance and financial assistance to community day-care programs for the retarded. The term "day care" has different meanings in different States; in Connecticut, it is applied to community classes or groups for retardates judged too young or too severely retarded to attend public-school programs for the trainable and educable. This again comprises a significant group of retardates.

Day-care programs have mushroomed throughout the State in the past 5 years. There is no question of their need, or of the fact that with more extensive day-care facilities, fewer children—even in the severely retarded category—would have to be institutionalized. A great deal of emotional pain could thus be spared retarded children and their parents, and the cost of institutional facilities and services could be reduced substantially.

Unfortunately, the day-care retardate today is lost in a no-man's-land. Educational authorities do not regard him as their responsibility, and there are no other public programs or facilities for him. Yet the difference between the trainable child in school and the school-age custodial child excluded from school may be only the difference of a few I.Q. points, or of inadequate training techniques, or of other factors that are by no means insurmountable.

Ever since its establishment in January 1956, with no State or Federal assistance, the Kennedy Center day-care program, the State's largest, has annually "graduated" a class of day-care children to public-school trainable classes. Some have even gone on to educable classes. Day-care classes, though still in their infancy in Connecticut and elsewhere in the Nation, have already demonstrated they can do a great deal to bring the retardate out of his shell, to overcome emotional obstacles, and to start the child on the road to good social adjustment.

The day-care class certainly represents as much of an educational process to the day-care child as the trainable class does to the trainable child. Does this not suggest that the educational role of Federal agencies under your committee's jurisdiction should be broadened to include day-care programs, provided that they incorporate training elements and are not merely custodial?

A great deal could be contributed in this area by Federal agencies. There is, for example, no such thing, anywhere in the Nation, to our knowledge, as a formal training program for day-care instructors. There are no manuals on methods and techniques; very few conferences and seminars; no body of educational or philosophical theory covering this increasingly important area. Yet the number of actual and potential day-care retardates no doubt exceeds the number of children in certain other groups of the handicapped who are, fortunately, already enjoying the benefits of Federal programs.

Another statute enacted by the 1959 Connecticut Legislature makes it mandatory for local school systems to provide classes for both the trainable and educable retarded.

Connecticut's experience with a permissive education law passed in 1953 has been similar to that of most of the States with such statutes. Six years after this law was passed, a majority of trainable children in the State either were not in classes or were attending on only a half-time basis. The chief argument against mandatory classes was that teachers were not available. This, of course, involved a vicious circle: As long as local school systems were not absolutely required to provide classes, many would make no special effort to obtain teachers.

The stimulus of legislation sponsored by your committee has been an important factor in swelling the ranks of teachers of the retarded, and will become progressively more important in the years ahead. Our States institutions of higher

learning have made outstanding strides in teacher training. No college or university in the Nation graduates more teachers of the retarded annually than Southern Connecticut State College in this very city. The University of Connecticut also has a well-developed special education program, and a program for teachers of the retarded was inaugurated this fall at Central Connecticut State College.

With the advent of mandatory classes and substantially increased enrollments in September 1961, however, the teacher shortage will undoubtedly become even more severe. Our association has urged in the past that new methods of obtaining additional teachers be explored. One such means might be adaptation of a highly successful Connecticut program whereby graduates of liberal arts courses have qualified as teachers of regular classes by taking accelerated courses. In the mental-retardation area, it may well be that less academic preparation is required for teachers and that more emphasis should be placed on inservice programs. This and other possibilities are at least worthy of exploration.

The Office of Education and other Federal agencies can make a very important contribution to the solution of teacher training, teacher recruitment, curricular, and innumerable other problems with which Connecticut and most other States are faced in meeting the needs of the retarded.

One particular educational area will take on special importance when the mandatory law takes effect next fall—the group between ages 16 and 21. As you are aware, the practice of most school systems has been to drop retardates when they reach 16. Connecticut's strengthened law means not only that these young people will remain in school, but that new programs must be devised so that they, the schools, and the community will receive the maximum possible benefit from their lengthened school years. Like many other States, Connecticut has major curricular and program needs in this age group. We look to the Federal Government for leadership in stimulating new and better approaches and techniques.

In closing, may I on behalf of our Connecticut association commend your committee on its decision to explore services for the retarded and unmet needs throughout the Nation, and for the time you are giving to this difficult and rewarding task. We are confident that as a result of your survey, great new horizons will be opened up, not only for the retarded but for all the handicapped of our Nation.

Mr. ELLIOTT. Is Dr. Ross R. Thomas here?

Is Mrs. Charles A. Donadeo here?

Mrs. DONADEO. Right here, sir.

Mr. ELLIOTT. Mrs. Donadeo is the president and founder of the Bridgeport Chapter for the National Organization for Mentally Ill Children.

Mrs. Donadeo, you may proceed.

STATEMENT OF MRS. CHARLES A. DONADEO, PRESIDENT AND FOUNDER, BRIDGEPORT CHAPTER, NATIONAL ORGANIZATION FOR MENTALLY ILL CHILDREN, CONNECTICUT

Mrs. DONADEO. I am Mrs. Donadeo, president of the Greater Bridgeport Chapter for the Mentally Ill Children, Inc.

We have devoted our time to this organization and we are just a group of volunteers that organized last March of 1959.

At this time we have about 15 children who are very much in need of help—mentally ill children. To operate this program it will take approximately \$20,000 a year, just for about 10 children. Of course, it would be very, very impossible to gain all this money from local funds and we have been, as the other man stated, giving card parties, food sales, rummage sales, to operate this program in Bridgeport. So we are appealing to you to help these forgotten children.

I think with proper care and treatment we could prevent them from being mentally ill adults.

Of course, I am not going to take a lot of time and I will make it brief, but I could leave this program; Or would the other people here like to hear our program?

Mr. ELLIOTT. Yes, ma'am, you may proceed.

Mrs. DONADEO. I will read it through.

The Greater Bridgeport Chapter of the National Organization for Mentally Ill Children was organized in March of 1959 after several months of study and planning. Its purpose is to help fill one of the most pressing and desperate needs in the field of mental health services in Greater Bridgeport: to provide help for the many seriously disturbed and mentally ill children in the area, children previously dismissed with a diagnosis of schizophrenia or autism.

Before its establishment, these children had nothing available to them. They were too ill to be helped by the usual program of the child guidance clinic, were not eligible for service from other agencies serving children, and, in fact, had no source of help on a continued basis anywhere in the state. Most of them could not attend school or nursery school and are too disturbed to even play with other children.

Realizing the tremendous need for help to these children and their families, the Greater Bridgeport chapter has set as its major goal the development of a special program for these forgotten children.

In addition to participating in the program of the National Organization for Mentally Ill Children by disseminating information, supporting research, and developing special facilities throughout the country, the following program is now underway. This has been worked out with the collaboration and cooperation of the board of directors and the staff of the Child Guidance Clinic of Greater Bridgeport, Inc.

PROGRAM

The current program consists of four parts. These are under the supervision of the staff of the child guidance clinic, which provides all professional and clinical direction. It has been in operation since March of 1959.

1. *Group therapy for parents.*—Recognizing the despair and confusion of their parents, this part of the program is designed to help them specifically in their handling of these children by sharing experiences with others, as well as group discussion of any particular problems. It also serves to provide support and relief from the tensions created by these children in the home.

Each group is limited to five sets of parents so as to give every one an opportunity to participate freely in the discussion. Meetings are held every 2 weeks from 8 to 10 p.m. These groups are led by staff members of the child guidance clinic.

2. *Evaluation of the children.*—This is designed not so much to provide a diagnosis (since most of these children have had one or more adequate diagnostic studies) but rather to develop a complete picture of the child and the way in which he functions.

The child is also studied as a member of the family and an attempt is made to provide the parents with as full an understanding of the child and his problems as possible.

Following the study, the parents are given an opportunity to discuss the findings and recommendations at considerable length and in as much detail as necessary with the psychiatrist and psychiatric social worker who have participated in the study.

Another function of this evaluation is to determine whether or not the child is capable of fitting into the third part of the program.

3. *Day care program for the children.*—This part of the program is planned to get underway in September and is designed to provide these youngsters with a positive group experience in a setting designed specifically for them under the leadership of a trained psychiatric group therapist who is experienced in working with disturbed children. It is planned to start this on a part-time basis, probably three 2-hour sessions a week, at first.

The group therapists will also work under the supervision of the medical director of the child guidance clinic. Each group will be limited to five or six children so that individual attention can be provided.

It is hoped to eventually expand this day care program so that children can attend every day and also throughout the summer, but at this point of beginning it is necessary to limit it somewhat,

4. *Individual treatment of children and parents.*—As special problems arise, or as the staff sees a need developing, one or more individual sessions with the parents or children may be held. This part of the program will be quite flexible and determined solely by the individual needs of the individual case.

POLICY

This program is made possible by the cooperative efforts of the Bridgeport Chapter of the National Organization for Mentally Ill Children and the Child Guidance Clinic of Greater Bridgeport, Inc. By special arrangement between the boards of directors of these two organizations, the chapter has contracted to reimburse the clinic for the costs of this program. The clinic, in turn, is allocating time for this program beyond its regular hours in order to make this essential work possible.

Who is eligible? Any child, resident in the Greater Bridgeport area, whose illness is such as to fall within the scope of this program.

How is this determined? Many children have already been studied and diagnosed since this type of mental illness usually makes its appearance within the first 3 years of life. Where there is question, the child may be referred to the clinic for preliminary screening. Any physician, parent, or agency may refer such a child.

How does the child get into the program? With the established diagnosis or following initial screening at the clinic, the parents are then referred to the Bridgeport chapter for inclusion in the program. After a brief conference with the parents at which time questions are answered and financial arrangements made, the clinic is notified of the acceptance of the child.

Following this notification, the clinic begins the evaluation, and then plans with the parents for participation in the other parts of the program.

It is important to mention that all medical and personal information about the child remains available only to the professional staff of the clinic which adheres strictly to the rules of medical confidentiality.

How is the program supported? Each parent is expected to pay what they can to help defray the costs. Through its various fund raising activities, the Bridgeport Chapter of the National Organization for Mentally Ill Children, underwrites the program in its entirety, in so doing it must rely to a great extent on the interest and support of the parents, families, and friends of the children, as well as all those in the community who are able to help provide some hope for these forgotten children and their despairing parents.

MR. ELLIOTT. I want to thank you for your testimony, Mrs. Donadeo.

Mrs. DONADEO. You are welcome.

MR. ELLIOTT. Our next witness is Mrs. Bertram A. Weinert, executive director, Stamford Community Council, Connecticut.

STATEMENT OF MRS. BERTRAM A. WEINERT, EXECUTIVE DIRECTOR, STAMFORD COMMUNITY COUNCIL, CONNECTICUT

Mrs. WEINERT. Thank you, sir.

I first want to thank you and the committee for the invitation on my behalf and also on behalf of the Stamford Community Council which is very much interested and involved in the rehabilitation field at the moment.

From them I want to convey the congratulations to the committee for their interest in this crucial matter.

Just very briefly I would like to look at a few statistics with you which we feel reveal the value of rehabilitative services to both the individual and country as a whole.

In 1956 there were 66,296 disabled persons who were returned to employment, to full employment.

In 1957 this group increased to 71,570 persons.

In 1958 there were 80,739.

It is estimated that the 71,570 men and women who were rehabilitated during fiscal 1957 increased their annual earnings from \$18,900,000 to approximately \$137 million.

Mr. ELLIOTT. Let me interrupt here to say to you, Mrs. Weinert, that it is estimated that the number for 1959 will be 90,000 for this year.

Mrs. WEINERT. That is something we did not have. I am very glad to hear it.

Actually, the committee and myself were very impressed, I mean our rehabilitation committee of Stamford and myself, were impressed with the fact that in 1 year of full employment of that group that was rehabilitated through 1957, in the year 1958 when they were fully employed their earnings rose from \$18,900,000 to \$137 million, \$137,600,000 and added approximately 900 million man-hours to the total Nation's productive effort.

Of that 71,570 persons, 53,000 were completely unemployed at the time they began rehabilitation and some 14,000 of that group had been completely dependent upon public assistance and were receiving financial aid from public agencies at the rate of \$11,400,000 a year.

For those 14,000 persons the total one-time cost of their rehabilitation was \$11 million.

Projecting some other figures that we are interested in in Stamford, because we are presently engaged in a chronic illness survey and this relates very intimately, as you know, to rehabilitation, just looking at that segment of the population in the over 65 group, the estimate is that by 1980, 23 million people will be 65 years or over and with the current rate of 57 percent of that age group in the present population having chronic illness or disabilities, it is estimated that by 1980 there will be 13 million relatively disabled older people.

This whole growing incidence of disability resulting from an ever-increasing life span really more than offsets any gains that have been made in conquering acute diseases such as tuberculosis, and the lack of personnel continues to be the primary factor we feel preventing more rapid extension of rehabilitative services.

Taking rehabilitation to mean restoration of total physical and emotional well-being there is a need to encourage programs to provide funds for training personnel in all fields and for research and for application in all fields, and by all fields we take it to mean medicine, psychiatry, psychology, social work, group work, occupational therapy, and vocational training.

Physicians in particular we feel are needed and Federal funds are required to assure a supply of well-trained doctors.

The Public Health Service estimates that the physician population should be about 133 to 100,000 people in the population and their figures indicate that this will drop to 125 per 100,000 if the present rate of graduation continues as it is from medical schools.

We feel that grants-in-aid to medical students directly and matching grants for medical school construction are needed to offset this probable change in the ratio.

Nurses are also needed to fill a critical shortage.

In New York City, for example, some figures were released where approximately 29 percent of the staff positions in the RN and PN categories were filled in the municipal hospitals.

Also, their salaries are amazingly low.

This feeling is that incentives in the form of scholarships and grants and supplementary income possibly should be provided to encourage girls to enter the nursing fields.

In Stamford we are particularly interested in placing nurses in training for specific work in chronic and convalescent hospitals, nursing homes which require very special types of training, with emphasis on rehabilitation.

We also feel specialists are needed in all areas of the rehabilitation field, particularly speech and hearing therapists and social workers to provide the essential social services that these settings require.

Also needed are personnel trained for the care of emotionally disturbed and the mentally retarded—psychologists, psychiatrists, social workers, and teachers.

Rehabilitative services which have proven to be so effective should be extended to aid those presently not reached.

The apparent common practice of committing to State hospitals the nonpsychiatric seniles is a shameful, wasteful, and inhuman means of avoiding a pressing problem.

Once we understand better what senility is we can provide better care for it.

There is need for research, pilot projects, and funds for the rehabilitation of the discharged, mentally disturbed patient who returns to his community.

There is a need for rehabilitative after-care programs and for community health care centers that bring psychiatric care nearer to the home of the patient.

We feel a major problem in the field of sociomedical rehabilitation is the time lag between the discovery of new knowledge in the medical field and in the rehabilitative field and its application.

We know that very often knowledge lies in warehouses as a result of delayed publication and very frequently articles are published in medical journals and seemingly never get to the practitioner.

It has been said that if we were to put to effective use all of our existing knowledge in chronic illness, rehabilitation, and mental retardation, we could do a 50-percent better job than we are now doing.

Preventative medicine is a case in point. In Stamford there has been a lot of talk of habilitation rather than rehabilitation and this should be our concern.

Scientific knowledge should be applied and applied to prevent illness and disability.

Early case finding is a major component of prevention.

It is felt this is a major weakness in the rehabilitation field. Method of case findings through parent education, professional education, and continuous health supervision should be encouraged by Federal legislation.

Rather than maintain people in idleness and futility there should be programs to seek out causes of disability and dependence, programs to prevent age disease, programs to begin the rehabilitation at point of diagnosis.

There is a need to emphasize the application of medical research for practical rehabilitation programs.

Another major problem, and this is what the committee in Stamford is particularly interested in, is the area of coordination of services and communications among them. There is a need for constant contact between agencies and between members of the helping professions.

There is need for broadly representative community planning and for central referral processes and for interchange of personnel.

Planning and coordination also requires training personnel.

Here, too, is a lack which can be eliminated by Federal grant and scholarships.

As important as the skilled professional working toward better services, even more significant is the need for community commitment, the local State and National community to the principles of complete high standard service of individuals and families.

Government can be of help through public policy statements along with specific legislation in encouraging citizen participation. Just as urban renewal requires citizen involvement in a workable program for redevelopment, so should public health planning require similar conditions.

Public health activities should be planned on a regional basis because of the increasing complexity of public problems in areas around metropolitan centers. Population shifts to suburban areas point to the need for a flexible program in public health.

In mentioning the suburbs, there is one point regarding education that should be touched upon since it appears to be considered a problem in urban centers only. Vocational guidance in elementary and secondary suburban schools is inadequate.

There is a need to improve local testing programs, local counseling and guidance services, and again, add personnel to that field.

Matching grants to States would be a valuable aid in this area. Also, serious attention should be paid to the alarming increase in the high school dropout rate.

Thought should be given to reconsidering the minimum age for compulsory school attendance. Many youngsters below 16 would benefit from counseling which would lead them, after a change in the law, to useful employment.

Returning to the field of rehabilitation, there is a need to aid chronically ill patients who are receiving care in facilities for acute patients. Many persons suffering from long-term illnesses are maintained in general hospitals merely because there is no place to go.

Federal encouragement for pilot projects and grants should be provided to establish homestead programs.

In the few instances where such programs have been set up, converted wings of hospitals have been used, and facilities utilized which were no longer needed for acute patients.

Goldwater Memorial, Elmhurst General, and Bird S. Coler Hospitals now have these programs.

The homestead separates the chronically disabled from the chronically ill. The former have permanent, often static disabilities and require infrequent medical and hospital services, as contrasted with the latter who require continuing medical care.

The homestead is a colorful, homelike setting which provides affection, Security, social contacts, self-expression, through creative activities, and has at hand the services of the hospital, if ever needed.

Comparative cost figures present a telling argument for such programs, when \$25 per diem is average cost of care in acute general hospitals, and \$8.50 is the per diem in a homestead.

Homestead programs should be established as one part of a gamut of facilities and services, including home care, general hospital, chronic disease hospital, nursing homes, after-care clinics, homemaker services, available to the chronically disabled.

In order to utilize this range of services, there is a need for the development of effective evaluation procedures. Funds for comprehensive evaluation processes should be made available to the Office of Vocational Rehabilitation for grants to local programs.

But in suggesting this, it should be emphasized that the comprehensive evaluation toward comprehensive rehabilitation is the goal. Beyond medical and vocational aims, there are the concerns of the goal; psychological, educational, and the improvement of daily living status.

It may not be out of order to suggest that the vocational, in the title of Federal and State bureaus, should be dropped and their orientation be more directed toward total rehabilitation under team supervision.

The bill, H.R. 3465, appears to be an excellent means of filling a gap in rehabilitation legislation. Assistance to States is needed for providing handicapped citizens greatly improved programs for the evaluation of rehabilitation potential, rehabilitation services for severely handicapped persons who can profit substantially from such services, but may not achieve vocational rehabilitation, and facilities for providing such services.

Title II, the independent living rehabilitation services portion of the bill, also would provide a program where none exists and the need is great.

Severely handicapped people can achieve remarkable results with the right kind of program. This has been demonstrated under existing services, the rehabilitation center is Stratford being a fine example of work with such cases.

Under title II many institutionalized and homebound disabled could reach a level of functioning which would free them for independent and fuller lives.

A particular benefit from both title II and title IV, the evaluation services section, would be that an agency no longer is required to decide in the beginning whether the handicapped individual can be vocationally rehabilitated.

This will result in the acceptance for services of many individuals who otherwise would have been rejected.

The gain to individual, family, and community is difficult to measure. But we can be assured that the investment in rehabilitative programs and grants for personnel training will strengthen our Nation.

It seems unbelievable that we explode millions of dollars worth of missiles in an attempt to find protection through weapons, while we neglect a far more basic and important protective need—the health and welfare of our greatest asset, the people.

Mr. ELLIOTT. Thank you very much.

Is Mr. N. Searle Light here?

Mr. LIGHT. I would like to introduce myself further, Mr. Chairman.

Mr. ELLIOTT. Mr. Light, our time limitation is 10 minutes.

You may proceed, sir.

STATEMENT OF N. SEARLE LIGHT, RETIRED, FROM CONNECTICUT STATE DEPARTMENT OF EDUCATION

Mr. LIGHT. I am going to confine myself pretty much to the statement on behalf of the gifted children who seem to be lost in the shuffle.

I listened to two telecasts, two broadcasts on the radio, and three newspapers, and no mention of the gifted children appeared in any one of them.

I think that suggests the nature of the problem we face in trying to provide something for these gifted children in our community and schools.

The crippled child attracts sympathy and the community does things for him.

I had charge of that work for those agencies, with those mentally and physically retarded for over 25 years in the State department of education. I am very deeply interested in them.

I have lived through the time when we had to fight to get children into those classes because of the opposition of parents.

The day has come now when the shoe is on the other foot and those classes are growing rapidly. Pretty soon it won't be long before 100 percent of the children will be cared for.

But nothing has happened as far as the gifted is concerned.

I did not know but I might stir up provocation this afternoon by saying that the gifted are handicapped too, but in a totally different way.

Incidentally, I think that in the management of administration, services to these people, the gifted do not belong in that special education section. They should be treated separately.

The people who are interested in the problems of the gifted are not interested in the problems of the other type of children and the reverse is true also. They just are not the same.

For the moment here I do not want to be misunderstood. In the first place, they are handicapped because of the teachers whom they meet in the school. These children are exceedingly gifted; they are very able, intellectually able.

They read widely and very often at times they are more accomplished than the teachers are and they are more able than their teachers are.

So we have a situation frequently when several of them have felt totally inadequate in the presence of those children in the room.

Not only that, but they were afraid of them. That has led a good many teachers to avoid servicing those classes with superior children. We need teachers. We need well-trained teachers.

We need teachers of superior ability to deal with those children. Those children are the biggest potential the country has so far as the future of America is concerned. It is time we began to do something for them.

The environment in which they work in the school frequently is not interesting to them at all. They are adults in a good many ways in

their reading and in their ability and the environment in which they have to work with children sometimes not of very high intelligence, is anything but stimulating to them. It is depressing. Sometimes it leads to a sense of frustration, hopelessness; they form bad work habits and frequently they drop out of school.

Much of what we think they need is adult material.

The secondary schools do not have too much of that material. They are shy the equipment material all the way through.

What they need is more of it, and of much more mature character than most of the schools maintain at the present time.

The fourth handicap under which they work is the reluctance of adults in the family and in the school to admit the existence of a dominant interest in these children at a comparatively early age. Statistics conflict telling us just how early these people finally make their choices, but they do develop these strong interests and the policy in some cases has been to discourage those, to get the children to postpone the decision until some time later.

One lady in our group was postponing that decision until after completion of the liberal arts program. A lot of these gifted children are not going to the liberal arts college. Those people are going to be painters, they are going to be sculpturers, your poets, your authors of note; people of that kind, as well as leaders in community work.

Those children are frustrated, leave school, we lose them at the end of the high school program. They are disappointed and depressed sometimes.

So I urge you to give serious consideration to what can be done for those children. We need better teachers.

We don't know enough how to handle these children. We need research.

The question of whether you are going to organize special classes for these children or special schools, who knows?

In this State there is not a community big enough to organize a special school for gifted children with all the facilities that that requires.

Should we build a regional school or what should we do?

It does not happen to be my problem. I am out of that picture now, but it does illustrate some of the need we face and which could be helped if provision could be made for a Federal aid and similar to what is done for other groups in the National Defense Act.

There some of the provisions of that bill are going to help gifted children, but not as a group.

The improvements in the teaching of science and improvements in teaching other subjects will undoubtedly react to their very definite advantage.

There are a lot of other areas in which they are not influenced at all. So I would pray that your committee will find it possible to make some provision for the gifted children in your program.

Thank you very much.

Mr. ELLIOTT. Thank you very much. You have made a very fine point, Mr. Light.

Is Mr. Edmund S. McLaughlin here?

Is Dr. Ralph J. Garry here?

Is Dr. Ross R. Thomas here?

Dr. THOMAS. Yes.

Mr. ELLIOTT. Dr. Thomas is psychologist at the Newington Hospital for Crippled Children at Newington, Conn.

Dr. Thomas, you may proceed subject to our time limitation.

STATEMENT OF ROSS R. THOMAS, PH. D., PSYCHOLOGIST, NEWINGTON HOSPITAL FOR CRIPPLED CHILDREN, NEWINGTON, CONN.

Dr. THOMAS. I would like to put these on some surface where they may be seen.

I will attempt to abbreviate my remarks.

I wish to particularly draw attention to this first chart on the cerebrally handicapped child in order to illustrate a point as regards what we call the multiple-handicapped child.

Too frequently legislation is concerned with only one part of this group and yet the cerebrally handicapped are very frequently straddling different groups. So the child who has cerebral palsy, who has the obvious neuromuscular disability, may also have mental retardation of varying degrees.

There may be epilepsy, there may be brain damage, behavior problems, and then entering into any one in combination may be speech, hearing, vision, and partial intellectual deficit.

We have in our experience, both present, the viewpoint of hospital school at Newington and also from the viewpoint of the medical staff, frequently encountered circumstances where over specific legislation dealing only with physically handicapped or mentally retarded has led to unfortunate results.

In the State of Connecticut there are classes and legislation which deal with those two groups particularly. Frequently, the parent prefers the child to go to a class for physically handicapped, whereas the child may have fairly severe mental retardation as well.

The upshot is that both groups, if there is any subdivision here, suffer, and those children who are physically handicapped, but who are of normal mentality, do not get as enriched a program in schools as they would if there was some discretion left to the State and local school board in terms of certain legislation, so that this kind of phenomenon condition would not arise.

That is my first main point, that there is a danger to overspecificity legislation which we wish to draw to your attention.

The second major point relative to this group is that research needs are overwhelming. We at Newington with the knowledge and moral support of the State board of education, are attempting to initiate an experimental demonstration class for children who show potential for near average achievement but who have some of the partial intellectual deficits of which I speak here.

This group we know exists. We do not know how many. We run across them in terms of children who are listed as cerebral palsy. We run across them with children who are thought to be generally mentally retarded.

We run across them where the major outstanding symptom seems to be the behavior deviation, but frequently this partial intellectual deficit is not detected until there is a very thoroughgoing evaluation, including a thoroughgoing psychological workout.

Unfortunately, we do not know the frequency. We do not know how many children are failing in classwork who could be assisted by a compensatory educational opportunity. I think we in Newington are particularly interested in this group of children who have varying partial handicaps intellectually.

You may have heard of the child who is aphasic, who cannot understand what he hears though his hearing is satisfactory, or the child who can hear and understand what he hears, but cannot organize a verbal response as one illustration.

Another illustration which we frequently meet with are children who have quite adequate speech but who cannot perceive visually the difference between forms such as is necessary for the learning of reading and writing. This latter group we refer to as visually perceptually involved children and we are particularly hoping to embark on a program for these children.

At present such classes do exist, but they are largely private, they are largely within the boundaries of major cities; and we think our class, if we manage to organize it, will be the first in Connecticut, and we hope we can eventually bring about a training program for teachers in our setting.

Now, I do think that the State board of education, given some latitude for the use of funds, given some source of funds for research and for the establishment of such classes, would probably have done so. I hope that something from the Federal level might assist, particularly in research, in these kinds of areas.

I think that the present sources of Federal grants too frequently are not available directly to the State boards of education wherein the most knowledge does exist as to needs within the State. We believe that financial subsidization for such research and experimentation should be made available to State boards of education.

Another major point illustrated by this group is the importance of interdisciplinary approach. We in Newington believe we can develop a cooperative program including the services of members from our educational, medical, social services, psychological staff. This is the total program for the cerebrally handicapped.

You will note perceptual handicaps in the third column.

We have actually seven different groups represented and then servicing all areas, but particularly perceptually handicapped, will be consultation with other specialists as well as therapeutic education, the demonstration class we hope to have, and parent counseling opportunities which would involve social services and psychiatry-psychology.

Now, what we feel here is that an interdisciplinary approach is important both in the research and in terms of the experimental educational program, since it is rather hard to carry out research or experimentation in education where the principal central fact is some medical condition such as brain injury without having available the medical specialist involved.

We feel that the research then, adding a sort of codicil to my last point, that some Federal fund specifically earmarked for interdisciplinary research, involving the medical fields and probably to be carried out in clinical centers where education is also carried out, would be a worthwhile program.

Finally, beside meeting research needs and emphasizing greater flexibility of legislation relating to special education, we believe assistance for teacher training for children represented by our chart is important.

The close relationship to medicine suggests that the teacher might best learn in a medical center where clinical data and medical information may be coordinated with the educational program. Scholarship assistance from the Federal Government for such training programs would be desirable.

Similarly, such scholarships are desirable for training teachers of almost any group, but the multiply handicapped is the one that we feel is particularly important in this regard.

Turning from this general group we would like to suggest provision for more vocationally oriented high school programs for retarded children. We note that these children often become increasingly despondent or hostile toward a program still largely focused on academic areas.

School "sheltered workshops" would, in our opinion, be more beneficial and provide for a natural transition into prevocational training in industry or additional training in vocational rehabilitation programs.

Thank you for this opportunity to express our views.

Mr. ELLIOTT. Dr. Thomas' formal statement will be made a part of the record at this point.

(The statement referred to follows:)

STATEMENT BY ROSS R. THOMAS, PH. D., STAFF CLINICAL PSYCHOLOGIST, NEWINGTON HOSPITAL FOR CRIPPLED CHILDREN, NEWINGTON, CONN.

Newington Hospital for Crippled Children is a private, nonprofit hospital serving residents of the State and financed largely by public subscription. We have a hospital school for inpatients. From experiences, both of the medical and educational staffs, we annually observe the effects of shortcomings in the public education system.

I would like to present one group of children—those with cerebral handicaps—as a group which illustrate several deficiencies in special education in our State. This chart displays the interrelatedness of a number of disorders—various combinations of which may be present in any one child. The central medical fact is neurological impairment—sometimes referred to as brain damage. The manifestations may be in neuromuscular difficulty (as in the obviously cerebral palsied), in epileptic symptoms, in behavioral disorders, in speech or sensory disorders, or in handicapping disturbances of intellect which ranges from severe mental retardation to limited dysfunctions which have the effect of preventing, or hindering educational gains.

General point 1 illustrated by this group: legislation to date is overspecific. Many of these children are multiply handicapped—retarded and physically handicapped—so does the child go to a class for retarded, or, as the parent usually desires, to a class for physically handicapped, which has the added benefit of provision for transportation. The net result is a disservice to all the children involved. It appears to us that overly specific legislation may tie the hands of the State and local boards of education. Such effects should be anticipated and, as far as possible, avoided—possibly by legislation which leaves more to the discretion of relevant boards.

Point 2: Research needs are overwhelming. We at Newington, with the knowledge and moral support of consultants from the State board of education, are trying to initiate an experimental-demonstration class for children who show potential for near average achievement but who have perceptual deficits which may exist as the main symptom or may be associated with neuromuscular and/or epileptic symptoms. We know these children exist—we know of scattered (and mainly private) classes for them in other States—and we know the State board

of education is concerned about these children. But—research is needed to determine the incidence of such disorders—conceivably a large proportion of children currently in retarded or opportunity classes as well as many children failing in the usual class setting have such disorders, which we have reason to believe can be greatly compensated for by proper educational experience. Research is also needed to further develop these special techniques of education.

Let me digress briefly to enlarge on the limited intellectual effects common to many cerebrally handicapped children. These have elsewhere been termed symptoms of "brain injury" or "brain damage"—symptoms which are manifested by discrepancies between different functions. Here are some examples: one group of conditions, termed aphasia, are shown in a person's inability to understand words although his hearing is unimpaired—or inability to produce speech although the speech apparatus is intact. Such children may—by means of signals or manual manipulation of materials, show that they are of normal intelligence in other regards. In the aphasic, therefore, there is inability to attach meaning to words and/or to organize a verbal response. This is a condition which often leads to improper placement in classes for the retarded.

A somewhat similar indication of partial deficit is shown in a child's inability to discriminate forms, or to produce forms by drawing. Frequently, we find these children can speak as well as their age group average—and even spell words verbally—but they may at the age of 11, 12, or older still be unable to read or write. We term this group perceptually handicapped in the visual sphere.

Many other variations occur—all indicating some potential for much better general functioning if the specific area of difficulty may be overcome or compensated for.

I recently saw such a child whose verbal IQ is very superior (130) but who is near dull normal in visualizing in his "mind's eye" the forms of letters and words he wishes to place on paper. Therefore, his achievement at school is only average. He is fortunate to be so intelligent in other regards that he can compensate for his poor area. The next child, in contrast, may be near average verbally but he has been unable to compensate—he doesn't read and may never do so.

Education and research in the instance of these children is either nonexistent or largely in the hands of private organizations. Sources of research grants at the national level too frequently are not available directly to State boards of education—where the most knowledge exists of needs for research and experimentation. We believe financial subsidization for such research and experimentation should be made available to State boards of education.

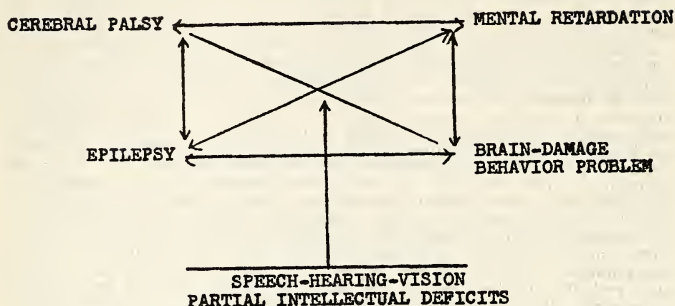
My third major point, as illustrated by this group—is the importance of interdisciplinary approaches. We at Newington believe we can develop a cooperative program including the services of members from our educational, medical, social service and psychological staffs. Seldom is this possible when research funds are allotted to individuals or organizations devoted to a single viewpoint. We would, therefore, attach a codicil to our last recommendation—namely, that research funds for special education should include funds specifically earmarked for interdisciplinary, cooperative research, preferably at clinical centers where medical and educational programs exist. As you will note from our chart, seven specialities are to be involved in our projected program for perceptually handicapped.

Finally, besides meeting research needs and emphasizing greater flexibility of legislation relating to special education, we believe assistance for teacher training for children represented by our chart is important. The close relationship to medicine suggests that teachers might best learn where they have ready access to clinical data and medical information—again interdisciplinary programs. Scholarship assistance from the Federal Government for such training programs would be desirable. Similarly, such scholarships are desirable for training teachers of multiply handicapped.

Turning from this general group we would like to suggest provision for more vocationally oriented high school programs for retarded children. We note that these children often become increasingly despondent or hostile toward a program still largely focused on academic areas. School sheltered workshops would, in our opinion, be more beneficial and provide for a natural transition into prevocational training in industry or additional training in vocational rehabilitation programs.

Thank you for this opportunity to express our views.

CEREBRALLY HANDICAPPED



Adapted from Hughes, James G., Second Tenn. Conf. on
Handicapped Children, 1958.

WEST HARTFORD, CONN., December 11, 1959.

ROSS THOMAS, Ph. D.
Newington Hospital for Crippled Children,
Newington, Conn.

In the practice of pediatrics in greater Hartford, it is evident that there are many unmet and unrecognized needs in the field of the cerebrally handicapped child. The greatest need is in the brain-damaged child with behavior problems and learning difficulties, requiring special attention and understanding. This includes those children with mixed-motor and mental handicaps. The children with motor handicaps are easily recognized and, therefore, have received the most help to date. Children with problems in communication; namely, speech and hearing deficits of any etiology, can be overlooked even in a community such as ours.

It should be our aim to find out the incidence of these and similar problems in an average community. The second need is for teachers with specialized training. They, in turn, should be able to set up a class for a limited number of children for the benefit of those children and as a teachers educational program.

The third need is for medical education and the dissemination of medical and educational information to professional personnel, especially physicians who deal with children, so they may be of value in diagnosis and treatment.

In the preschoolchild and in children who are now in school, I am sure we could find an unexpectedly large number with intellectual defects and I believe that all efforts should be made to determine the magnitude of this problem and set up facilities for their management.

I hope this information will be of help and lead to increased interest and support in the coming years.

FREDERICK J. FLYNN, M.D

Mr. ELLIOTT. The next witness is Mr. Frank Looney, director of welfare, New Haven, Conn.

Mr. Looney, we are pleased to have you.

Because of our time limitation we have had to limit our witnesses to 10 minutes.

STATEMENT OF FRANCIS W. LOONEY, DIRECTOR OF WELFARE,
NEW HAVEN, CONN.

Mr. LOONEY. As the director of New Haven's welfare department, I welcome the opportunity of appearing before this subcommittee which is evaluating the need for the extension of rehabilitation services.

From the framework of the public welfare agency—and I think we are particularly responsive to the ebbs and flows of our economy—we see the need from the point of view of the productivity of our clients.

Increasingly, we observe a continuing rise in the numbers of people on our relief rolls who are employable, but for whom no employment can be found.

In an expanding labor market many of these persons are absorbed, but in a depressed market there is no room for them.

For these people are, by and large, the marginal workers and their importance to the job market depends upon how much their marginal efforts are needed. For them, there is no job stability, no long-range planning. They drift in and out of jobs, never quite getting enough skill to make their next move a better one for them and their families. They are the last to be hired and the first to be fired.

These are the people unskilled in the use of machines and blueprints; they are the poorly educated, whose life has been of hard work from an early age on farms, or other forms of manual labor; they are the mentally deficient and mentally ill, and also the persons with physical deformities or limitations, whose handicap has prevented them from being absorbed into the job market.

In a sample of our caseload we found that approximately 60 percent of our relief clients had some form of emotional, mental, or physical handicap.

The depressing feature about this group is that, lacking any planning and help with its problems, it tends to feed upon itself.

In our department, for example, the so-called employable rose from 25 percent of the total caseload in 1954 to almost 40 percent in 1959.

With hope for job improvement waning, turned away for lack of skill, the simple passage of time itself tends to make society, including their neighbors, friends, and even their children, put these people aside as unable to take a responsible role in a competitive world. This group forms the hard core of dependency on the relief roles in our city.

Because of our great concern with this problem, we have attempted to do something about it within the structure of public welfare, but with only modest success because of the need for a coordinated, intensive approach by many disciplines.

We have, for example, set up our own employment unit, hoping that we could direct some of the least wanted employees on relief into the job market.

We have also given a battery of tests to a selected group of 1958 employable men and women and we were disheartened at the very small number who showed any real potential for ready employment.

For even those who scored fairly well it was clearly indicated that job placement without rehabilitation and retraining would be difficult.

Both of these pilot studies have demonstrated the inadequacy of piecemeal attempts to resolve the inertia which grips large numbers of our clients. We know that unless concerted and sustained services are provided to get at roots, then simple treatment of branches will be of no avail.

The need for increased rehabilitative services is urgently evident in our urban society. Our welfare burdens and our community problems will mount unless we find the way to halt the trend toward apathy, the loss of motivation, and the lack of interest in the community and its institutions.

The manpower loss to the area of this group is truly enormous when reviewed from their unproductive lives. But it borders on the catastrophic when we think in terms of the human values that have been allowed to deteriorate just because a man has lost faith in himself and because his family can no longer entertain any hope that he will live to the capacity and potential with which he started life on this earth.

For some of this group the pattern is so firmly established, the ego structure so deteriorated from repeated rejection in the labor market that prolonged efforts at rehabilitation may be uneconomical, but the least among them is entitled to a thorough screening, testing, and evaluation before a decision is made to discard them as non-productive members of society.

Many of these may be salvaged in part through a sheltered workshop which utilizes a limited amount of productive effort of which they are capable.

Of greater concern is the younger, less-damaged group who could be redirected economically through retraining and rehabilitation to a significant level of self-sufficiency and independence.

It is true that we have in New Haven some excellent facilities and agencies engaged in rehabilitation activities and our welfare clientele have benefited from the use of these services.

However, there is an acknowledged need for continued growth and expansion of these services to reach into areas and help people who cannot now be accommodated within existing limitations of staff and facilities.

The value of these services is evident in the statistics of our New Haven Area Rehabilitation Center. Of 376 adults treated and discharged 37 percent achieved full-time or part-time employment or housewife status. Almost another third went back to school or college or achieved an improved status. The final third were classified as not improved.

Mayor Lee in his opening address yesterday made particular reference to H.R. 3465, which, if enacted, would provide funds for aiding the development of new and enlarged rehabilitation facilities for our community.

As city welfare director, for the reasons cited above, I also heartily endorse legislation of this kind.

It has been well stated by an ancient philosopher that:

The noblest charity is to prevent a man from accepting charity; the best alms one to show and to enable a man to dispense with alms.

Thank you, gentlemen.

MR. ELLIOTT. Do you have a copy of your statement?

MR. LOONEY. Yes.

MR. ELLIOTT. I would like to have it. I want to capture that last quote you gave.

MR. LOONEY. Do you have any questions?

MR. ELLIOTT. No, thank you. We thank you for your testimony.

MR. LOONEY. Yes, sir.

MR. ELLIOTT. Our next witness is Dr. Edith S. Lisansky, secretary-treasurer, Connecticut State Psychological Society.

Is Dr. Lisansky here?

DR. LISANSKY. Yes, sir.

MR. ELLIOTT. You may proceed.

STATEMENT OF EDITH S. LISANSKY, SECRETARY-TREASURER, CONNECTICUT STATE PSYCHOLOGICAL SOCIETY

DR. LISANSKY. You have heard a good deal these two days about the very real problems of educating the handicapped and helping them to become useful members of society standing on their own feet.

The bill, H.R. 3465, has as its goal not only the teaching of a trade or the fitting of a prosthetic device, but the more ambitious and very admirable goal of rehabilitating for independent living.

What the bill offers, in effect, is a basic American principle: It is better to stand independently on your own feet than to live out your life in an institution, dependent on others.

In institutional living—no matter how good the institution—some individuality and the right to make one's own decisions has to be surrendered.

I would like, speaking as a psychologist, to direct your attention to a question which concerns my profession. The bill, H.R. 3465, states under definitions, on page 12:

The term "independent living rehabilitation services" means counseling, psychological and related services.

However, the services—listed on page 16—which rehabilitation facilities are supposed to offer are not all clearly defined. What, for example, is "(v) adjustment training"?

Adjustment to what? Does such adjustment training include counseling and psychotherapy?

I am not talking here about friendly advice giving. We have all, at one time or another in our lives, turned to a parent or a friend or a colleague for advice. Counseling and psychotherapy is not this kind of friendly chat, nor is the admonition by one person to another that he stop worrying.

Psychotherapy is, rather, a highly skilled technique of treating emotionally upset people and it requires training and experience. It is a safe assumption that most of those whom the bill would seek to benefit would profit immeasurably from such psychotherapy.

The mentally ill: It is apparent that such treatment is indispensable in the rehabilitation of the mentally ill.

During 1950, about one and a quarter million people were in public and private mental hospitals. It's a safe prediction that the numbers will be even larger in 1960.

It is estimated that there are between 3 and 4 million alcoholics in the United States. If one adds to this roll the mentally ill criminals, the drug addicts, and all the emotionally disturbed people who are not hospitalized, but who seek help through clinics and private practitioners, it adds up to one of the most challenging health problems of our time.

The handicapped: In addition to the mentally ill, there are those physically handicapped persons who carry along with their other disabilities the emotional consequences of their handicap.

To be crippled or blind imposes burdens of mental pain, and it is a rare handicapped person who escapes painful, scarring emotional experiences. These people need help in using prosthetic devices and in special education, but they need as much to be helped in adjusting to society in such a way that they can lead satisfying, productive lives.

What it comes down to is that we psychologists cannot conceive of a total push on the problems of rehabilitation which does not make available in all instances counseling and psychotherapy.

If this is what adjustment training means, good, but it needs spelling out.

Our recommendation is that every treatment center, every curative workshop, every rehabilitation unit, include on their staffs at least one professional individual trained to do psychotherapy; psychologist, psychiatrist, psychiatric social worker.

Mr. ELLIOTT. How do you define psychotherapy?

Dr. LISANSKY. It is a highly involved technique which is a verbal interchange between two people in which the psychotherapist attempts to help the other person face up to the problems which disturb him, to face up to the issues which disturb him, and to handle them in such a way so that he can function better by working through the thing in the interchange between therapists and patient.

There are 375 psychologists in the State of Connecticut who are members of the American Psychological Association. Most of these psychologists have a doctor of philosophy degree, which represents a minimum of 3 years training after college graduation.

Most of the 375 are clinical psychologists. And clinical psychologists are being trained, not only to administer and interpret mental tests, but in the skills of counseling and psychotherapy.

The trainee is supervised in this work until he acquired the know-how and the experience to work on his own. Here, among these psychologists, is one untapped source of personnel to help cope with the overwhelming psychological treatment needs of the handicapped and the mentally ill.

Mr. ELLIOTT. Are we not very short of psychotherapists, psychologists?

Dr. LISANSKY. We are fantastically short of them.

It seems to me as though the need mounts at a rate. Even if we train at the rate we are doing it will not keep up with the need.

Mr. ELLIOTT. The need mounts faster than the proportion that would derive from the passing of time?

Dr. LISANSKY. There is a question whether mental illness is on the increase in the United States. The impression of most of us who work in this field is that although there are no clear-cut statistics on this, it seems as though it is, it is mounting at a faster rate than the population is mounting.

This may be because we are recognizing it more readily than we did before, or cause of greater stress or maybe in society where people do not have to struggle to look for a living and don't have to struggle and worry about three meals a day and shelter that somehow people become more anxious about things they cannot afford to be anxious about when they are struggling.

Whatever is the basis it does seem as though the need is mounting much more rapidly.

Mr. ELLIOTT. All of that illustrates the fact that in this field we are yet babes in the woods. We really do not know and we need research and we need fellowships.

Dr. LISANSKY. Exactly.

I had thought about making some point today about research need, but I was sure this would be raised by a number of people.

There is no question that we know much more about it than we did 50 years ago, but we don't know enough. It is admittedly trial and error, but we work with the best we have.

Mr. ELLIOTT. The fellow who built America by felling trees and plowing with oxen, who worked from sunrise to sundown, also hoped that he could provide for his children—if not his children, his grandchildren, some of the luxuries and the ease about which he dreamed.

Now, when we as a civilization achieved, though it may be temporary, we have achieved that degree of luxury and ease we apparently don't know what to do with it, or at least, our knowledge about these stresses of which you spoke that create mental illness is so little that we do not know what to make of the future.

I have been quite interested in a solution of that problem and I wondered whether or not the philosophy of my grandfather that everybody ought to work from sunup to sundown, at least 6 days a week, may not have been a pretty good one.

Dr. LISANSKY. I am sure it would be very good, but unfortunately we cannot create this artificially. We are reaching an age of automation and it is apparent that before too long we will be down to 30 or 20 hour work weeks.

The great problem I think, that confronts us when we give people the leisure is then what. When we make strides in medicine that permits people to live longer, then what.

We have given the people all this time and leisure, but we have not yet solved this problem how to live a satisfactory life with this leisure.

Mr. ELLIOTT. Then we come along and we say to everybody that since we have made your life longer and we have cut the workweek and we have provided time at least for leisure, and recreation, we say to the worker who may be in perfectly good health he has to quit at 65 or sometimes 60 or 62.

It seems to me that sometimes the cruelty of our civilized rules is very great in that respect.

I can think of nothing more cruel than to stop a man from working who is in the prime of life and in the prime of knowledge of his

occupation and to say to him that you are chronologically 62 years of age and you have to quit.

It seems to me that a lot of this, certainly from the standpoint of mental illness, that we are not decreasing the mental strain when we say to a perfectly satisfied worker that you have to quit tomorrow. The strain following such an experience is often—and I am not a trained person in this field—observable, I think, by even the layman.

Dr. LISANSKY. It is such an artificial situation. In the universities, for example, there is a mandatory age of retirement. It varies from one university to the next, but it varies from 73 to 65.

Most men who have been teaching and thinking most of their life have not reached the point of senility at 60 or 65. Yet the rule is that they must retire at that point.

It has always seemed to me to be grossly cruel and unfair. It seems to be more cruel and unfair in the case of individuals who do not have resources within themselves to live with in their remaining years.

The thing that I seem to observe most among the older people I notice that when you take work away from them you not only rob them of the sense of usefulness, but they don't have anything left to fill it with and yet they are energetic and active enough.

Now, I think eventually we are going to have to work out some kind of system, perhaps of part time work or getting society organized in such a way so that there are constructive things that the aged population can do.

Mr. ELLIOTT. I have a correspondent who has been writing me about his intentions to establish a dozen factories on an experimental basis about the country to work elderly people 4 hours instead of 8, work them from 8 to 12, one crew or shift, and from 2 to 6, or probably 1 to 5 the second shift, but to have a complete change of shift.

He thinks that that in an industrial field may be part of the solution.

There seems to be no reason why one arbitrarily should decide a man is not to work when he reaches a particular age.

I have taken some of your time but I will give you some of my time.

Dr. SILANSKY. I want to raise a point that I gather was raised yesterday. It is a point I am not altogether clear about. That point is about the handicapped children.

This bill, H.R. 3465, refers to handicapped persons of employable age. What I have just said about handicapped adults, their need of help in dealing with emotional problems, requires, I think, even more emphasis in dealing with youngsters.

With those under 16 we are given more effective in lightening the emotional burden they carry in heading off more serious problems.

We know that handicapped children have a hard time developing into sound adults. If such a child is fortunate, he may have a good home and the most understanding of parents who do not make him feel like a cross they bear or like a helpless invalid who must be perpetually dependent on them. Much more typical is the handicapped child who is being crippled emotionally as he grows up by the ever present, painful awareness that there are things other people can do and enjoy that he cannot.

This is the major point we psychologists would like to make.

Prosthetic devices are not enough. Special education and vocational training are not enough.

Emotional rehabilitation: counseling and psychotherapy, needs to be available in all rehabilitation programs for adults and for children, which used to be available in all recreational programs for adults and children.

Perhaps you can spend a few seconds explaining to me why the bill just covers individuals of employable age.

Mr. ELLIOTT. The bill is sort of like a complaint that a lawyer might file when his client gets his fingers mashed off. He always sues for a lot more than he thinks he will get.

The analogy with respect to the bill is this: The bill is just a working model. The suggestions for changes that you make are very, very good, and they will be taken into consideration.

The bill that we finally bring out of this committee, in my judgment, will not bear too much resemblance to the bills that are before us. The bills that are before us are working models. They are somebody's ideas of a starting point.

We will endeavor to improve those as we go along.

Your testimony has been very helpful, and I thank you very much, Dr. Lisansky.

Now, Captain Donovan, I told you that you would be next.

You will be limited to 10 minutes, and you may proceed.

STATEMENT OF CAPT. JEROME F. DONOVAN, MEMBER, BOARD OF THE ALEXANDER GRAHAM BELL ASSOCIATION FOR THE DEAF

Mr. DONOVAN. Mr. Elliott and members of the committee, I am grateful for your invitation to appear before this committee in my dual role as the father of a deaf child and as a member of the board of the Alexander Graham Bell Association for the Deaf.

In both capacities I desire, first of all, to give my unqualified support to House Joint Resolution 494.

I feel that I can best justify my support by telling you the story of my deaf daughter. It is quite personal, but I feel that it will open another window on the problem of education of the deaf.

Mary is the youngest of our five children. She is just 16. We did not realize that she was deaf until she was about 2½ years old, when she should have been doing quite a bit of baby talking. She was noisy enough, but suddenly it dawned on us that she did not respond unless she was looking at the source of the speech.

Clinical tests proved our suspicions, and we were advised to train her as a deaf child. Our knowledge in this field was nonexistent, and Johns Hopkins directed us to the Volta Bureau of the Alexander Graham Bell Association.

We were furnished invaluable advice on schools and correspondence courses.

Mrs. Donovan and I then visited most of the oral schools on the east coast, but they were either filled, or were not equipped to handle Mary on a full-time boarding basis, which was a necessary condition to my service duty at that time.

We were finally fortunate enough to have Mary accepted by St. Joseph Institute for the Deaf in University City, Mo., where she has been a student for 12 years. She will graduate this year, has usable speech, and unusual facility in lip reading. She is going back next year for a postgraduate course, in order to orient her further for a useful life in the world of the hearing.

I tell you these things because I know that we are among the most fortunate of parents. Our child has received a fine education, combined with love and understanding. She is accepted by our community in her own right, and she has brought the problem of the deaf to many of our townspeople, to their great enlightenment.

She is a fine athlete with many friends, and is probably the best known member of our family among the younger generation.

On a personal note, she has done great things for our family in teaching unity and purpose.

Now, the point of all this leads up to the fact that there are, to my knowledge, many, many families with the same problem, who cannot get an adequate education for their deaf children. We hear from them, and we try to help them, but there just aren't enough qualified educators to handle them.

My oldest daughter became so keenly aware of this that after graduation from college, she took graduate work and is now a teacher of the deaf at the Lexington School in New York. My three sons do their share as well.

Deafness is a profound thing. To see the light in the eyes of a child who hears through sight is truly inspiring. Education of the deaf cannot work miracles, but it can, when provided for, come awfully close.

MR. ELLIOTT. Thank you very much, Captain Donovan. That is an inspiring story.

MR. DONOVAN. Thank you, sir.

MR. ELLIOTT. Now, I promised to recognize John A. Kirchner, because he came down early from his post as chief of otolaryngology in the Department of Surgery, Yale University.

Dr. Kirchner, will you come around, please sir.

STATEMENT OF DR. JOHN A. KIRCHNER, CHIEF, OTOLARYNGOLOGY SECTION, DEPARTMENT OF SURGERY, YALE UNIVERSITY

DR. KIRCHNER. I am very grateful for this opportunity and for the invitation of the committee to appear here.

I would like to make just two or three points on the bill No. 494 which I think should be in your thinking as this goes into final form.

In the surveys that are made in the school systems the school nurses go through the schools and test the hearing of children in the third grade, in the sixth grade, or whatever it is, and they do in fact find 4 or 5 percent of children with hearing impairments.

Now, of this 4 or 5 percent, some of them are deaf only in one ear, so that they are not a handicapping problem.

Many children go through life, or until they are tested, with one ear completely deaf and they think this is the way people hear and they do quite well in their school work.

On the other hand, those who are hard of hearing in both ears will fall into two groups. They fall into group of nerve-deafened children, as Captain Donovan just explained to you, and these are problems in special education. They are terrible problems.

The other group, however, which makes up most of the group of hearing problems that are uncovered in surveys, are what we call conductive deafness.

Now, this is due to recurrent ear infections or obstructions by adenoid tissues or tonsils, sinus infections. These are medical problems. They are not problems in education at all.

We can cure most of these, as has been pointed out in the bill here, except they did not point out that they are remedial, but it does not say by medical means.

These children are not problems in education. They are problems for medical treatment.

Now, in this bill on page 2, whereas some 8 million Americans of all ages suffer from speech or hearing impairments or so forth, this makes up about 5 percent of the population, I think, roughly between 4 and 5 percent.

This, I believe, includes these conductive-deafened children or people with medical conditions.

I do think that this is something that should be looked into a little. These are not problems in education at all.

The next premise, that this large section of the population suffers from hearing, speech defects, the majority of which are remedial, again there should be added "by medical means."

The next premise, whereas 20,000 speech pathologists and audiologists are needed to properly diagnose training and train people, this is a little misleading because if you are dealing with nerve-deafened people you need a teacher of the deaf.

The speech pathologists and audiologists should work in a medical setting where they are seeing the great mass of people who have medical conditions who can be treated and helped. These people should be trained in the medical setting. They should not be trained in schools of speech, in my opinion, because, of those that we have had from schools of speech and education, it has been a year before they have been able to acquire enough clinical feeling to really be much help to us.

It takes at least a year in a medical setting.

The other point I would like to make here is on page 5 on the Advisory Committee of the Commissioner of the 12 people there is not a physician among the 12. Six of them are to be engaged in teaching the deaf; three are to be from institutions of higher education, affiliated again with institutions where they are training teachers of the deaf, and three shall be individuals representative of the lay public who have demonstrated an interest in the education of the deaf. I think a little medical diagnosis might be in order on a problem this large.

The last point I would like to make is on the first page, whereas at least six of the institutions accredited for the training of the teachers of deaf have no trainees enrolled for the current academic year, I would raise the question: Why haven't they?

I do not think that setting up stipends and scholarships is going to attract people into this field. It is rewarding for people who are emotionally and psychologically attuned to it who can work with an individual for long periods of time and years and see just a little progress but it does not attract people generally. I think in talk you would find more people interested in audiology or speech pathology than you would in training deaf children.

The results are faster and I think much more rewarding to the average person. It takes a special type to go into teaching of the deaf. I think that of this group the figures that are quoted here are far too high, the number of people that are going to be needed. Twenty thousand speech pathologists and audiologists: I would seriously doubt this. I think the physicians can cure a great many children who, I think, are going to be seen by this group, the way the bill is written. This is all I would like to bring out, Mr. Chairman. If you have any questions to direct to me, I shall be glad to try to answer them.

Mr. ELLIOTT. I just want to thank you, Doctor, for giving us the benefit of your observations about the bill. You have made some very excellent points for me.

Dr. KIRCHNER. Thank you very much.

Mr. ELLIOTT. Now, then, our next witness is Dr. S. Justus McKinley, president of Emerson College, Boston, Mass.

STATEMENT OF CHARLES J. KLIM, ASSISTANT PROFESSOR, SPEECH PATHOLOGY, EMERSON COLLEGE, BOSTON, MASS.

Dr. KLIM. I am Dr. Klim, from Emerson. I spoke earlier this morning. Dr. McKinley said because of the last day of college if he could not come or did not arrive on his time that I was to go on record as to support for him the 494 and 371 and also the recommendation made yesterday and turned in by Mr. Philbrick on the speech workshop that was carried on during the week. So in order not to take up any more time I think that will be sufficient for this purpose.

Mr. ELLIOTT. Thank you very much.

Now, is Dr. Burton Blatt here, professor and chairman, Speech Education Department, Southern Connecticut State College, New Haven?

STATEMENT OF BURTON BLATT, ED. D., PROFESSOR AND CHAIRMAN, SPECIAL EDUCATION DEPARTMENT, SOUTHERN CONNECTICUT STATE COLLEGE

Mr. BLATT. I appreciate this opportunity to testify before this committee. I would like to make three points in reference to special education for the mentally handicapped.

Now, the enactment of Public Law 85-962 in September 1958 will undoubtedly prepare more teachers of the mentally handicapped through the training of college instructors. There is real doubt that the quality of the new teachers prepared, albeit in great numbers, will be very much improved.

The enactment of this bill is an important milestone and it was a good bill. However, I think the Federal Government should spon-

sor legislation to support Federal grants for research in better ways to prepare teachers of mentally handicapped children and teachers of other kinds of handicaps. So far as I know there has been no project ever supported by the Federal Government in the Department of Health, Education, and Welfare in investigations into ways in which we can better prepare teachers.

For example, most of our teachers being prepared today are prepared through the traditional modes and lectures, discussions, visitations, student teaching.

I have a particular feeling that we can do better for these teachers through a more clinical type of education, similar in some respects to the education of physicians and psychologists.

I speak particularly of a program that we inaugurated a year ago whereby we provide extensive observations of children in an observation room having one-way vision and hearing, where we can observe the children with a master teacher and where the students can learn their theory through observation of children and post mortems in our clinic afterward; this, in addition to the lectures, discussions, visitations, and student teaching, we feel strongly, will prepare better teachers.

We have submitted a research proposal to the Federal Government in order to make an extensive investigation of this particular technique and we hope that it will be accepted. This is only one method. I think that there are many, many other ways we can do a better job of preparing teachers. I think because of the great need for special class teachers today, too many of us are forgetting the fact that the quality of this preparation is in many ways more important than the numbers we graduate.

It has been said in the past that in many places special education is neither special nor can it be considered education and to provide classrooms for 15 children to sit with a teacher who is unprepared or not as qualified as she can be, is probably to do no more for this child than if we would leave this child in the regular grades.

My second point is in a request for the Federal Government to investigate methods through legislation to support institutions that have been attracting large numbers of superior students who are willing to major in this program.

This is not a common situation. Most universities and colleges cannot attract students. However, there are some, and we are one of them, that have, year by year, turned away many qualified people who have completed 2 years of college and wish to major in our program and we have no room. We can point this out by citing a few statistics.

We have at the present time in our junior and senior undergraduate program 87 students who are majoring in the program to prepare as teachers of the mentally handicapped.

According to our surveys this probably represents the largest undergraduate department of special education in the country. We will need by September 1961 in the State of Connecticut, because of the passage of mandatory legislation for both trainable and educable children, a minimum of 193 new teachers based on a 2 percent incidence of mental retardation which is a very conservative incidence, and probably as many as 500 to 526 teachers based on a 3 percent incidence.

Our college, plus the students that will be graduated from the graduate program at the University of Connecticut, and the University of Hartford, will, together, prepare 150 candidates to meet this need by 1961.

In spite of a severe shortage by 1961 our college will probably have to turn away 100 students who want to major in our program.

At the present time we estimate we have 150 to 175 speech education majors.

Now, what I am proposing as a possible way to solve this problem is for the Federal Government to pass legislation to provide specialists through the Health, Education, and Welfare Department to be assigned to particular colleges for 1 or 2 year periods. I am asking this because many colleges than can expand, that have the students to expand, are reluctant, in view of the fact that when you hire a new faculty member you are almost arranging a marriage that is for life, and if the enrollments continue to increase, then the college is happy, but if the enrollment the next year goes down the college is left with a faculty member without an assignment.

I propose that the Federal Government sponsor legislation for those programs that are willing and able to expand greatly and rapidly for the first year or two of this expansion to see how far this expansion will go and if it will continue.

This will permit the college to expand without feeling pressured by a sudden loss of students in the years to come.

I think in addition to this, and I am not sure how the Federal Government can make this next request, money must be appropriated for library materials for institutions of higher learning that have such programs.

The libraries in many, many institutions of higher learning are very inadequate in these specialized fields.

My third point is to request the Federal Government to support projects and ideas that have been trying to reject the stereotyped, straitjacketed atmosphere commented on in the literature and in our work.

Unfortunately there is a great discrepancy at this time between what research tells us and what is practiced and what is taught in our colleges.

I would like to submit to you a paper that I have recently written, entitled "Some Persistently Recurring Assumptions Concerning the Mentally Subnormal."

If I may take a minute to read 10 quick conclusions into the record, you may be able to appreciate the differences between feeling and teaching and what our research tells us.

These conclusions:

1. Blatt, Burton, "The Role of the State Teachers College in the Preparation of Teachers of the Mentally Handicapped," *American Journal of Mental Deficiency*, 63: 942-947, May 1959.

2. Fields, Harold, chairman, "Who Makes the Best Teachers of Mentally Retarded Children?" *American Journal of Mental Deficiency*, 58-259, October 1953.

3. ———, "Thoughts About College," *the Goddard Bulletin*, 21: 1, May 1956.

4. Goldberg, I. Ignacy, "Profiles in Special Education Personnel," *Exceptional Children*, 23: 240, March 1957.

5. Lord, F. E., and Wallace, Merry Maude, "Recruitment of Special Education Teachers," *Exceptional Children*, 15: 173, March 1949.

6. Mackie, Romaine P., "Some Problems in the Education of Handicapped Children." Federal Security Agency, Pamphlet No. 112, Washington, U.S. Government Printing Office, 1952. 12 pp.

7. Mackie, Romaine P., and others, "Teachers of Children Who Are Mentally Retarded." U.S. Department of Health, Education, and Welfare, Washington, U.S. Government Printing Office, Bulletin No. 3, 1957, pages 68, 69.

8. Tenny, John W., "Preparing Teachers of Mentally Handicapped Children," *American Journal of Mental Deficiency*, 58: 566-572, April 1954.

9. Tessmer, Eleanor, and others, "Undergraduate College Training Facilities for Teachers of the Mentally Handicapped." Unpublished student report, New Haven State Teachers College, 1957.

I think the Federal Government can help us all in a coordination of thinking and a sharing of research findings through a clearinghouse of research that would function in disseminating the vast hoard of research data that is being accumulated through the generosity of the Federal Government and other agencies.

I think the Federal Government can help us through the publication of bulletins and abstracts of findings in this field, both from the United States and foreign countries.

I think that the Federal Government can help us through the publication of monographs that would otherwise not be published due to the financial cost involved.

I think the Federal Government can help us through the sponsorship of workshops and seminars of regional nature to share these theories in research findings.

I appreciate your invitation to me.

Mr. ELLIOTT. Thank you, Dr. Blatt.

(The formal statement of Dr. Blatt follows:)

SOME PERSISTENTLY RECURRING ASSUMPTIONS CONCERNING THE MENTALLY SUBNORMAL^{1, 2, 3}

"believe those who are seekin gthe truth; doubt those who find it"

—*André Gide*

(By Burton Blatt, Ed. D., professor and chairman, Special Education Department, Southern Connecticut State College)

In 1948, Goldstein published a penetrating paper dealing with causes, characteristics, and implications of mental deficiency.⁴ This work received a great deal of attention, partly, it is supposed, because of its clear and readable style (a rare and commendable achievement today) and, more importantly, because

¹ Presented at the Workshop in the Rehabilitation of the Cerebrally Palsied and Other Disabled Persons, Springfield College, Springfield, Mass., July 8, 1959; presented at the Council for Exceptional Children, regional meeting, Providence, R.I., Nov. 17, 1959.

² The author is indebted to George Brabner, Jr., and Seymour B. Sarason for their valuable suggestions and encouraging support.

³ Because of the absence of a consistent and universal nomenclature, it should be pointed out that, for the purpose of this paper, the term "mentally subnormal" is used as an all-inclusive classification embracing all individuals functioning below normal intellectually.

⁴ Goldstein, I., "Implications of Mental Deficiency," *Occupational Education*. 5: 149-172, 1948 ("mental deficiency" is used here generically).

it purported to separate fact from fiction, " * * cite the fact, nail the lie; construe the implication; act."⁵

Goldstein's paper originally deserved its place of prominence as a recapitulation of existent practices and assumptions from which were derived a series of definitive statements concerning mental subnormality. However, evidence brought forth during the decade since the publication of his work and the disconcerting questions raised by research completed, and suggestive of research yet to be done, limits the usefulness of his article to its gross impact in upgrading the understanding of the unsophisticated and the uncritical. Today, the student examines "Implications of Mental Deficiency" and is not sure what is fact and what is fiction, what is myth and what is reality.

Because of the continuing tendency of many special educators and researchers to base decisions and actions on unwarranted assumptions, and considering the diligent research of those who have provided a few answers during the past years, it is desirable at this point to reexamine some of Goldstein's facts, determine their right to this label, and offer other possibilities for consideration. Unfortunately, much of Goldstein's position of 10 years ago is, today, accorded almost universally unqualified acceptance by teachers, authors, other professionals, and institutions of higher learning. Therefore, the purposes of this paper seem clear: to reduce the rigidity of a profession that resists change; to provoke the creative to seek answers; and to instill a healthy unrest in all who work with the mentally subnormal.

I. FACT OR FICTION?

"Mental deficiency is basically a physical or constitutional defect. Abnormal, incomplete, or arrested growth of certain cells results in the crippled arm, the crippled leg. Similarly, although not always as outwardly apparent as in the instance of the crippled leg, deficiencies in brain structure or defects of somatic organization result in mental deficiency. Mental retardation is thus a symptom of some constitutional disturbance or defect."⁶

Analysis: A review of pertinent literature leads one to the unmistakable conclusion that children, variously called mentally retarded, subcultural, "familial," nonorganic, acclinical or garden variety, do not, as a group, upon the most thorough neurological and psychological examinations, exhibit " * * deficiencies in brain structure or defects of somatic organization." Sarason and Gladwin sum up the neurological consensus by stating that the mentally retarded, who constitute the bulk of those in public school special classes and the majority of "high grade" institutionalized children, presumably do not exhibit any central nervous system pathology.⁷ They call attention to the need to differentiate this group, called mentally retarded, from the mentally deficient who have demonstrable central nervous system disorders and who probably will never achieve a normal social and intellectual status.

Therefore, in the absence of any evidence to the contrary and until that time when such evidence is forthcoming, mentally retarded children who exhibit no central nervous system pathology should be assumed free of constitutional disturbances that in some way act to produce inferior intellectual development. It appears to this writer, from the standpoints of educational programing and research, that an uncritical adherence to a traditionally all-inclusive concept of mental subnormality, which rules out the possibility that these children have intact central nervous systems that have capacities for at least typical development, is a dubious practice for the following reasons:

1. Such a viewpoint is unduly restrictive to the researcher in that its emphasis on the apparent irremediability and constitutionality of this condition detracts from potentially promising investigations into the role of cultural and psychological variables on mental subnormality.

⁵ Ibid., p. 149.

⁶ Ibid., p. 150.

⁷ Sarason, S. B., and Gladwin, T., "Psychological and Cultural Problems in Mental Subnormality: A Review of Research," *Genetic Psychology Monographs*, vol. 57, 1958, p. 17. (Also published in monograph form in the May 1958 issue of the *American Journal of Mental Deficiency* and in the Basic Books Edition of 1958. In addition, it is included in the 1959 edition of Sarason's "Psychological Problems in Mental Deficiency.")

2. It establishes unwarranted limitations on what might be attempted and accomplished educationally with mentally subnormal individuals to improve their intellectual, social and psychological functioning.

3. It relegates to public school special classes for the mentally subnormal, thousands of children for whom such "educational" placement may not be indicated in the light of our professional understanding and knowledge, or justified on the basis of a "diagnosis" of mental retardation. This "diagnosis" and placement largely determines the future course of the lives of these children.

4. It engenders in the teacher a predeterministic mental set which discourages experimentation and hope in the classroom.

5. A positive position does not assume that, in the absence of demonstrable central nervous system disorder, the possibility of organicity is ruled out. Rather, it recognizes that neurological procedures and criteria are not now completely valid or reliable and this positive position is taken in the interests of research and experimentation.

Implication: If this large group of children, described above, does not exhibit central nervous systems that are different from the typical group, the question to be asked is, "Why are these children mentally subnormal?" It must be determined whether these children are subnormal as a result of functional rather than constitutional causes. It should be noted that the evidence available, albeit scanty, points to the conclusion that a great number of those children, presently classified as mentally retarded, cannot be so classified using Goldstein's definition.

II. FACT OR FICTION?

"Mental deficiency exists from birth or early age * * *⁸ * * * is incurable and irremediable."⁹

Analysis: As long ago as 1952, Kirk cautiously generalized that nurture may be an important underestimated factor in the causation of mental subnormality—not all mental deficiency exists from birth or an early age.¹⁰ In trying to locate preschool children with IQ's between 45 and 80 for an experimental study, Kirk contacted schools for the names of siblings of known school-age retardates, social agencies, clinics, pediatricians, and public health department officials. His search was relatively unsuccessful. He found a few children " * * * referred by doctors were grossly deficient, with retardation usually of organic nature, but a large percentage of children from all of these sources was found to be of average intelligence * * *"¹¹ Since it is generally agreed that high-grade mental defectives are frequently found in subcultural environments and, as a result of Kirk's lack of success in finding such children at preschool ages, there is a suggestion:

" * * * that many children later placed in special classes or institutions are not mentally retarded in terms of intelligence test scores at the ages of three, four, or five. Some children, whose older brothers and sisters were in special classes, tested approximately normal at the preschool ages. This raises the question as to whether children from low cultural levels who are approximately normal at an early age may later become mentally retarded because of their cultural environment or other unknown variables."¹²

Implication: Kirk's experiments with the early education of the mentally subnormal once again raises the controversy of nature versus nurture in the development of intelligence. In a recent (1958) publication, describing the results of a 5-year experiment analyzing the effects of preschool education on 81 young mentally retarded children, Kirk outlines both the nativist and environmentalist points of view.¹³ The nativist's position is clear: intelligence is mainly a factor of central nervous system maturation from conception on; children grow evenly at their own rates; early stimulation will not increase potential; mentally subnormal children cannot be made "normal," regardless of any kind of training or education now known; when such changes in intelligence do occur, they are more than likely due to errors of original diagnosis; mental subnormality is incurable and irremediable.

⁸ Goldstein, op. cit., p. 151.

⁹ Ibid., p. 150.

¹⁰ Kirk, S. A., "Experiments in the Early Training of the Mentally Retarded," *American Journal of Mental Deficiency*, 56: 692-700, 1952.

¹¹ Ibid., p. 697.

¹² Ibid., p. 698.

¹³ Kirk, S. A., "Early Education of the Mentally Retarded," 216 pages.

The position of the environmentalists is less clearcut but, from this viewpoint, more promising: within broad limitations, the development of children is significantly affected by the kinds of early rearing they have experienced; to explain all changes in intelligence as being due to erroneous original diagnosis only beg these intriguing questions. Why are researchers unable to locate preschool educable mentally handicapped children? What are the conditions that promote increments in intelligence among certain children?

A review of Kirk's findings raises the following questions in the mind of the serious student:

1. What is the significance of the acceleration in rates of growth of 30 (in a total sample of 43) children who received preschool education?

2. Why did the study disclose that it was much more difficult to displace the rates of growth of organic children than nonorganic children? (However, one may argue that the apparent irreversible defect, of the organic child may be due to the educator's inability to adequately compensate for this defect. A dramatic example of the use of compensatory educational techniques can be found in a study of the education of Helen Keller).

3. Why was it generally found that the greater the changes made in the environment, the greater were the changes in the rates of growth?

It is interesting to note that: familial educable children do not usually exhibit mental subnormality during the preschool years (the Columbia University research project on the effect of group training on 4- and 5-year-old children who are mentally retarded, has unofficially reported similar findings); familial educable adults marry, find jobs, solve problems on a typical level, and maintain themselves independently and indistinguishably in the community;¹⁴ it appears that only when this individual is of school age, is he diagnosed and does he function as mentally subnormal; it appears almost as if the schools predestine the child to mental subnormalcy. Therefore, it would seem logical to designate the nature—nurture issue an open one and to find answers to the following problems:

1. What is the relationship of cultural and psychological variables to early rearing practices and their effects on intellectual growth and development?

2. What are the factors comprising this general ability we call intelligence and how can they be more adequately measured?

3. What is the relationship, if any, between test problem-solving behavior and nontest problem-solving behavior? Do different racial, religious, and cultural groups score differently on conventional tests of intelligence because of actual differences in innate intelligence or because of the ways children are brought up to solve problems?

4. What is the relationship between motivation and status goals? Is academic achievement a status goal of all who go to school?

III. FACT OR FICTION?

Mental subnormality “* * * results in the inability of the individual to profit from ordinary schooling * * *”¹⁵ and “* * * by providing him with a different educational program suited to his needs, we can make him more capable of facing the world which lies ahead of him.”¹⁶

Analysis: No one, who has worked with mentally subnormal children in school, would question the validity of Goldstein's remarks. However, one may question the implication that there is substantial evidence as to what the proper program should be. From his article, one can conclude that retarded children in special classes are receiving a great deal more purposeful education than retarded children in regular classes.

In a rare moment of candidness, a distinguished special educator recently remarked, during a meeting in which this writer participated, that special education isn't special nor can it, in many instances be considered education. Studies find that, insofar as measurable abilities are concerned, mentally handicapped children in special classes are very similar in development to those in regular

¹⁴ Sarason and Gladwin, op. cit., pp. 13-50.

¹⁵ Goldstein, op. cit., p. 151.

¹⁶ Ibid., p. 165.

grades.¹⁷ In fact, the earlier studies of Bennett and Pertsch found that retarded children in special classes did poorly in physical, personality, and academic areas as compared with retarded children in regular classes. Later studies by Blatt and Cassidy found few significant differences between those children in the regular classes and those in special classes. Notwithstanding the many valid criticisms of studies comparing special versus regular class membership, it has yet to be demonstrated that special classes offer a better school experience for retarded children than does regular class placement.¹⁸

Certainly, there is little evidence to support the fact that special class provisions, even the best available today, are the millennium; nor can we even say that the best of our special classes are "good enough."

Implication: Disturbing as it may be to those who have conscientiously developed curriculums for the mentally handicapped, and while providing convenient rationalizations for the "do-nothings" who reject responsibility by saying either we do not know enough to plan or each teacher should plan according to the individuals in her class, there is little evidence to support the widespread notion that, by placing mentally handicapped children in conventional special classes, society is meeting their educational needs. There is no doubt that this group of children, regardless of etiology or permanence of condition, requires special provisions in school. There is doubt, at least among some educators and psychologists, as to what should constitute the program of special education and who can benefit from it. In this regard, some intriguing questions to be asked are:

1. How many children are placed in special classes after careful differential diagnosis? How many are placed after the simple administration of Binet and WISC tests? Does the administration of these tests constitute a differential diagnosis?

2. Using more than the limited evaluations to be derived from the IQ, how many children in special classes do not belong there? Do we have a moral obligation to these children regarding diagnosis, placement, and the ultimate effects of these on their lives?

3. What are the best ways to teach mentally subnormal children to read, to understand numbers, to understand themselves? What is different about the methods, materials, and content in special classes commonly found today?

4. What is really meant by the statements:

(a) "She is not a good student but she may make a good teacher."

(b) "This person isn't a skilled teacher but she has a good attitude. She will not do any harm to children."

(c) "We can't measure the differences, but these children in the special class are receiving a finer education than if they were to remain in the regular grades."

Do these statements indicate that we don't know how to evaluate special education because we, as yet, do not know what special education should be?

The implication here is evident. What is needed is an infusion of bold, creative thinking into the field. Experimentation with new and unorthodox methods and materials must be encouraged. A more discerning study of the mountain of research in education, special education, psychology, anthropology, and sociology must be made in order to separate the valuable from the nonessential. We must reject many of our present curriculum practices because they have been so eminently unsuccessful. When Goldstein describes the retarded as " * * * incapable of logical thought, unable to make generalizations or work with abstractions," and therefore, " * * * responses must be habituated. He must be taught specific responses to specific situations," is he merely perpetuating the retardation with the supposed educational treatment?¹⁹ Is there

¹⁷ Bennett, A., "A Comparative Study of Subnormal Children in the Elementary Grades." 81 pp.

Blatt, B., "The Physical, Personality, and Academic Status of Children Who Are Mentally Retarded, Attending Special Classes as Compared With Children Who Are Mentally Retarded Attending Regular Classes." 134 pp. (Also published as an article, *American Journal of Mental Deficiency*, 62: 810-818, 1958.)

Cassidy, V. M., and Stanton, J. E., "An Investigation of Factors Involved in the Educational Placement of Mentally Retarded Children." 93 pp.

Pertsch, C. F., "A Comparative Study of the Progress of Subnormal Pupils in the Grades and in Special Classes." 101 pp.

¹⁸ Blatt, op. cit., pp. 11-14.

Cowen, P. A., "Special Class vs. Grade Groups for Subnormal Pupils," *School and Society*, 48: 27-28, 1938.

¹⁹ Goldstein, op. cit., p. 152.

the possibility that, for some children, the retardation is due to an early rearing emphasizing habituation? Can some retarded children profit from programs involving creative thought processes rather than from the continuation of "straitjacketed" stereotyped curriculums which reflect the same kind of thinking?

IV. FACT OR FICTION?

"The general consensus at the present time seems to be that 40 to 50 percent of mental deficiency are of a hereditary nature * * *"²⁰

Analysis: The recent work of Sarason and Gladwin has pointed up the meagerness of the evidence subscribed to by adherents to hereditary theories of mental subnormality.²¹ Their investigations have convinced them:

"* * * that a hereditary determinant of mental capacity must not be assumed to exist unless proven. Furthermore, proof should be sought in terms of our present knowledge of human genetics and of the nature of human intellect, rather than, as is commonly done through the administration of routine intelligence tests to a variety of 'racial' and other groups. We do not propose to deny that heredity is a factor, particularly in mental deficiency, but rather that we should leave it out of our accounting until it is supported by more than speculation and bias."²²

Implication: Every day, recommendations are being made in regard to sterilization, prohibition of marriage, court placement of children, and counseling of adults—all based on the assumption that mental subnormality has a genetic basis. Should such crucial decisions be made without more evidence? What are the genetic factors, if any, in the causation of mental subnormality?

V. FACT OR FICTION?

"He (the mentally subnormal) is more liable to illness and physical defects and generally lacks the physical stamina of the normal child."²³

Analysis: Blatt reviewed a great many studies:

"* * * concerning the physical status of children who are mentally retarded. Although there was disagreement among researchers, the consensus seems to indicate that there is a positive relationship between intelligence and various indexes of physique. However, this relationship is not invariable and appears to be too minor to be useful for predictive or educational purposes. This relationship does not appear to be linear in character and it may be more significant in the more severely retarded group."²⁴

The mentally deficient are not necessarily "limited in physical prowess."²⁵ Especially among the group called familial, there are many who far surpass the norm in every aspect of physical ability. Mentally subnormal children do not have to be malnourished. They do not have to be poor athletes. They are weak for the same reasons that typical children are weak; they are strong for the same reasons. Because a significant percentage of these children reside in substandard environments and because a significant percentage have central nervous system impairment, some retarded children are physically limited. The bulk of those in the "higher grade" category are not.

Implication: Mentally subnormal children do not necessarily have to be physically limited. To assume that these children are so limited because of mental inability is to use a handy but poor excuse to remain inactive when rehabilitation may be indicated. We do not explain malnourishment in a gifted child by quoting his high IQ; evidence dictates that we do no less for the subnormal. It is ironical that, as a group, mentally subnormal children both in special and regular classes surpass their academic expectancy as measured against their mental age.²⁶ In spite of this, special class teachers continue to feel their greatest anxiety in reconciling actual reading and arithmetic achieve-

²⁰ Ibid., p. 152.

²¹ Sarason and Gladwin, *op. cit.*, pp. 63-78.

²² Ibid., p. 63.

²³ Goldstein, *op. cit.*, p. 152.

²⁴ Blatt, *op. cit.*, pp. 50-51.

²⁵ Goldstein, *op. cit.*, p. 155. (Studies of characteristics of the mentally retarded, using this term generically, often become meaningless because of differences in abilities among the various subgroups considered retarded. Particularly in the area of physical status, it should be emphasized that there are very significant differences between organic and nonorganic children and between higher grade and lower grade children.)

²⁶ Blatt, *op. cit.*, pp. 45-50, 98.

ment of children with what teachers expect and hope for. Fewer teachers have anxious moments rationalizing physical education and health programs for these children regardless of what is being accomplished and what can be accomplished.

VI. FACT OR FICTION?

"Early studies (circa 1900), purporting to show that as high as 85 percent of delinquents and criminals in the studies were mentally deficient, have been challenged. Today the figure is believed to be closer to 50 percent."²⁷

Analysis: In a recent review of the literature, Blatt found numerous studies, with few exceptions written at least 15 years ago, reporting high relationships between delinquency and intelligence.²⁸ More recent research reports low relationships, "J" shaped in character, and suggest the following factors that influence these relationships and affect their validities:

1. There appears to be a multiplicity of causes of criminality and delinquency. Lower IQ, per se, does not play an important role in the causation of such behavior unless this factor combines with other causes (as Goldstein points out) such as: poor homes, mental disease, alcoholism, and marital strife among adults and school failures, poor neighborhoods, unrealistic education, and community rejection toward children.

2. Some delinquents receive low IQ scores on tests because of their sub-cultural environment rather than as a result of constitutional defect.

3. There are selective factors operating with respect to the intelligence level of delinquents in institutions. One institution may not admit the subnormal while another may care for this type of child exclusively.

4. Brighter delinquents may escape detection and apprehension.

5. On the basis of a more promising prognosis, the mentally able delinquent may receive a suspended sentence while the subnormal child, committing the same act, may be placed in an institution.

In summary, " * * * it appears that the retarded are more frequently represented among delinquent populations than typical groups but this representation may not be as significant as once was believed. It is probable that the relationship between intelligence and delinquency is 'J' shaped in character. The group known as 'borderline normal' may comprise the most significant population among delinquents."²⁹

Implication: Mentally subnormal children do not have to become delinquents; nor can we explain delinquency as a manifestation of the subnormality. It is not surprising that some of these children become delinquents; it is amazing that more do not. Society must recognize the need for psychiatric and social services, realistic education, and vocational counseling for all its citizens. More importantly, we must cease looking with derision at those in a different cultural milieu.

CONCLUSIONS

1. A great many children, presently classified as "familial" mentally subnormal, should be assumed free of constitutional deficiencies or genetic aberrations that may result in inferior intellectual development.

2. A great many children, presently classified as mentally subnormal, cannot be so classified using the conventional definition that requires constitutional defect.

3. There is impressive evidence that numerous children, presently classified as mentally subnormal, acquire this subnormality sometime after birth or early age.

4. There is impressive evidence that numerous children and adults, originally classified as mentally subnormal, could not be so classified on later evaluations.

5. There is impressive evidence that the role of cultural and psychological variables in the causation of mental subnormality has been greatly underestimated.

6. There is little evidence to support the widespread practice of placing educable mentally subnormal children in conventional special classes rather than in the regular grades or in some other, as yet unknown, more suitable classes.

²⁷ Goldstein, op. cit., p. 154.

²⁸ Blatt, op. cit., pp. 39-45.

²⁹ Ibid., p. 811 (of A.J.M.D. article, see footnote 14, reference 2).

7. There is a dearth of convincing evidence supporting any hereditary theories of mental subnormality.

8. As a group, educable mentally subnormal children are not significantly different in physical attributes from typical children.

9. There are low relationships, "J" shaped in character, between delinquency and intelligence.

10. Many of the present assumptions in the field of mental subnormality are unsubstantiated by valid evidence, are reinforced with prejudice, and flourish in an atmosphere of rigid and stereotyped thinking.

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Mr. ELLIOTT. According to my list that is all the witnesses listed for today with the exception of Mr. Warren MacIsaac, the Calasanctius Preparatory School, Buffalo, N.Y.

Mr. MacIsaac has traveled quite a ways to be with us. We will hear him at this time.

We are trying to finish, however. If you will make your statement as brief as you can we will appreciate it.

STATEMENT OF WARREN MacISAAC, THE CALASANCTIUS PREPARATORY SCHOOL, BUFFALO, N.Y.

Mr. MACISAAC. I shall. Anything I might say in support of the request that the Federal Government assist schools that are designed for students of exceptionally superior intellectual ability would be a mere echo to the mountains of publicity the subject has received in recent months, indeed, years.

Our own school is perhaps representative. There are very few schools such as ours. It is an independent school, that is to say, unlike some of the schools for gifted children which are supported by communities, public schools.

Mr. ELLIOTT. Is yours a school for gifted children?

Mr. MACISAAC. It is indeed, sir.

Our elementary requirement is an IQ admission of 130 or above measured on the Wechsler-Bellevue intelligence scale for children.

Mr. ELLIOTT. How many children do you have?

Mr. MACISAAC. We have 82 children at the present time.

Mr. ELLIOTT. You have to look around thoroughly to find somebody with above 130; do you not?

Mr. MACISAAC. We do indeed. We have some students whose combined score would seem to be lower, but whose exceptional ability in one particular area of the test would warrant the risk of admitting the students.

Mr. ELLIOTT. Have you had any experience yet as to what happens to these children after they finish school?

Mr. MACISAAC. No, sir; the school is now in its third year. It is contending with its financial problems in its efforts to experiment with curriculum.

We are in some measures feeling our way although the headmaster is an experienced teacher in the education of gifted children.

We have received some gifts from the Buffalo Foundation and a grant from the Federal Government under the National Education Defense Act for building a laboratory.

We are trying to raise funds for a new building, but all of this is much too individual. The general statement the headmaster asked me to make was that as an independent school we are essentially a church school; the school is owned by the Piarist Order, a Catholic teaching order, which is very well known in the United States. Consequently, it is not attached to any bishopric and, therefore, has no sources from within its religious category. The school has half or more of its students presently under scholarship at considerable sacrifice.

The parents are industrious in trying to raise funds. In short, we would like to suggest that a project of this kind be regarded as a consideration of the Government and such grant as the \$5,600 that the school received from the Government earlier be enlarged.

The statement I have with me typifies the particular needs of our school, but they are not a request to pay our bills, but rather that we are trying to do things which are unique and very difficult to complete—for instance, the school teaches Arabic, which requires some peculiar settings. It requires, in the first place, an unusual teacher, unusual vocabulary, and alphabet.

We have introduced Chinese on a part-time basis. We have only one or two students who are making much progress with it.

Altogether these are the issues with which gifted children of the United States are faced.

I think the observation of Alfred North Whitehead 43 years ago is one of the most appropriate at this time:

When one considers in its length and its breadth the importance of this question of education of a nation's young, the broken lives, the defected hopes, the national failures which result from the frivolous inertia with which it is treated, it is difficult to restrain within one's self a savage rage. In the conditions of modern life the rule is absolute; the race which does not value trained intelligence is doomed. Not all your social charm, not all your wit, not all your victories on land or at sea can move back the finger of faith. Today, we maintain ourselves. Tomorrow, science will have moved forward yet one more step, and there will be no appeal from the judgment which will then be pronounced on the uneducated.

There are few schools such as ours. We would like very much to have consideration of Federal assistance.

Thank you very much.

Mr. ELLIOTT. Thank you very much.

(The following material was submitted:)

RÉSUMÉ OF AN EXPERIMENTAL PROJECT IN THE EDUCATION OF GIFTED CHILDREN,
BY ALFRED NORTH WHITEHEAD

Title: Calasancius Preparatory School; experiment in the more effective scientific and humanistic education of gifted boys from 10 to 16.

Sponsoring organization: The Calasancius Preparatory School is conducted as a day and boarding school by the order of the Piarist Fathers, Inc., Buffalo, N.Y. This organization is tax exempt as a nonprofit organization and is listed in the Official Catholic Directory on pages: 834-47A and 339.

Address: Calasancius Preparatory School, 120 Rumsey Road, Buffalo 9, N.Y.

Directors of the project: Rev. Stephen Gerencser, S.P., Ph. D., S.T.D., headmaster of the Calasancius Preparatory School, director and coordinator of the project; vice directors: For sciences: Y. Ramon Perez, M.D.; For mathematics: Ellsworth V. Pound, Ph. D., professor emeritus, University of Buffalo; for humanities: Rev. Michael Palotai, S.P., M.A.; executive secretary of the project: Charles R. Kent, M.A.; treasurer: Rev. Henry Mirowski, S.P. M.A.

PURPOSES

In the much neglected field of the education of gifted youths 9-16 years, to pilot a new program and methods toward a more efficient scientific and humanistic education:

(1) To foster the maximum all-round development of which the boy is capable.

(2) Through research and experiments, to improve curricula, texts, and methods of instruction.

Although the school is established for gifted boys, it is hoped that it will benefit not only gifted children, but the students of all American schools.

HISTORICAL BACKGROUND

After many years spent studying the problems of education for gifted youth, the director of this project came to the same conclusion as many thinking Americans: we are wasting our most valuable asset—our gifted youth—in failing to give them an education that will challenge their intellects and help them to utilize to the fullest their potentialities as productive individuals and contributing members of our society.

The school was opened in the fall of 1957 with 16 students in a building given to the school for use for the 1957-58 school year at 1 Agassiz Circle, Buffalo, N.Y. For the 1958-59 school year the Calasancius Preparatory School moved into its own home (cf. more detailed report in the annual report), 120 Rumsey Road, Buffalo 9, N.Y. The same building served as school building in the 1959-60 school year also.

The number of enrolled students:

Year	Preentrance	I Form	II Form	III Form	Total
1957-58		16			16
1958-59	7	26	14		47
1959-60	8	A:19 B:23	20	12	82

Entrance requirement: Achievement tests and the Wechsler-Bellevue intelligence test for children. The IQ rating should be 130 or above, or in exceptional cases (special ability in certain fields) around 130. Boys are accepted without discrimination in social status, race, or religion.

THE PROJECT AS PLANNED

(1) An experimental phase, to last 6 years, in order to test the planned curriculum and proposed methods;

(2) A continuing phase, in which the school will be maintained along the lines established and evaluated during the first or experimental phase.

TIMELINESS

The climate would seem conducive and the time very ripe for this experiment. Public awareness of the dangers threatening the intellectual development and leadership of America has never been so great as now. As the statement by the President's Science Advisory Committee emphasizes: "Our changing civilization will demand in the future an even greater devotion to learning and a greater pride in intellectual achievement" (p. 30).

In all the four areas outlined by the Committee—(1) The curriculum and content of courses, (2) the quality and effectiveness of teachers, (3) the recognition and encouragement of students, and (4) the development of intellectual leadership—the directors of the Calasandrus Preparatory School are convinced that something positive and valuable can be contributed through our experimental project.

The solution to our present-day educational problems is not a mere increase in the number of schools or extension of the time required for education but rather in the fullest utilization of the intellectual and material resources available.

PROPOSED APPROACH AND METHODS

The stated goal is not new; indeed, there are today more and more educators becoming concerned over the problem of gifted children in our present educational system, but it is the conviction of the directors of this project that this project has some specifically unique aspects:

(1) A vertical program in all subjects.

(2) A new science program in sequence, content, and integration.

(3) New aspects in the teaching of history, with special emphasis upon the very much neglected Afro-Asiatic civilizations.

(4) Introduction of intensive language study at an early age, not only of those languages usually taught in our educational system but oriental languages as well.

(5) A unified and ascending program for 6 years, continuous in one school and with a closely interrelated curriculum.

(6) Specifically related field studies in close integration with the subjects taught in the classroom.

PERSONNEL

The teaching personnel is composed in part of members of a teaching order with a longstanding tradition, who individually have extensive academic preparation and practical teaching backgrounds, and in part-time laymen and laywomen selected for their training in their respective fields and for their dedication to the project.

Advisers are qualified and eminent men in their fields and they are assisting the project as academic or as financial advisory board members.

EXPECTED RESULTS

We expect that this program will result in rich contributions to the development of curriculum, especially in sciences, history, and languages; in more productive use of the years of study between the ages of 10 and 16. We expect that the project will contribute to the recognition and encouragement of students, especially of those with outstanding ability, and to the quality and effectiveness of teaching.

While certain results are expected and indeed can be seen after 2 years of operation, it would be premature to make definite statements of the results before the end of the first 3 years. Tentative remarks about the progress of the school are made in the first and second annual reports. The precise formulation of the results in a more detailed form may be expected at the end of the first 6 years.

We plan to publish progress reports annually describing the development of the project.

FINANCIAL PROBLEMS

(1) The project's beginnings and progress were and are financed with the contributions of parents interested in the education of their children, of the members of the Order of the Piarist Fathers, and certain members of the lay faculty, who give their time without any reimbursement to the project, and with limited contributions from local businessmen and other friends of the school. One local foundation (Buffalo Foundation) assisted our laboratory program with \$5,000 and the Federal Government (under the National Educational Defense Act) granted a \$5,600 loan for laboratory development.

(2) The project is presently operating from the 120 Rumsey Road, Buffalo, N.Y., property. This former mansion served well the purpose of the school during the transitional period. But the time definitely has arrived when positive steps should be taken to have a final location for the school, with all the necessary laboratories and space needed to develop our program according to our principles. For the promoting of the building of an appropriate plant, a building committee was organized at the end of 1959 among the parents and friends of the school, with the clear purpose of reaching a definite solution by 1961 at the latest.

(3) For the time being the project depends in its operation very much on tuitions and the free contributions of one part of the faculty. But we feel that this dependence and our very liberal scholarship policy may jeopardize the purpose of the school by making it difficult or impossible to select students solely upon the basis of intellectual ability. The ideal situation would be to operate the school as a free school, without any dependence whatsoever upon tuitions or personal sacrifices.

SPECIFIC NEEDS

(1) *Necessary funds for—*

(a) Science building capable of accommodating our science program.

(b) A combined building, or system of buildings, to accommodate the library, classrooms, etc., in the value: \$1 million to \$1,500,000.

(2) *Teaching personnel.*—The ideal solution would be to have the necessary endowment for the establishment of teaching posts, especially in the following fields (if the school reaches full development):

Humanistic-language group: Latin, Spanish, French, German, oriental languages (part time).

Religion and psychology: World history, American history, art, music.

Mathematics: Two teachers.

Sciences: Biology, chemistry, physics, geography-geology.

Our aim is to give proper monetary compensation to our teachers so that they may dedicate their entire energy to teaching and research, preparing textbooks, and to proper educational approaches to the education of the gifted, leaving opportunity during their vacation period for further studies.

(3) *Teaching fund.*—Our overall objective in this respect is to insure that the financing of teaching and research work will not have to be dependent on tuitions or the episodic aspects of emergency drives and fund-raising affairs. The latter, of course, have been quite necessary in the absence of any endowment or dependable regular source of income, and at the same time it has been necessary for the individual members of the faculty to make many personal sacrifices. The permanent establishment of one chair for teaching and research, it is estimated, would necessitate a capital yielding \$8,000 per year.

(4) *Scholarship fund.*—As it is one of our overriding principles to make this educational program available to any boy with recognizable talent and proper motivation, we have from the start not refused any otherwise qualified student whose parents have not been able to pay the tuition. To make possible the

realization of this ideal, the members of the faculty have, during the first year of operation, sacrificed several thousand dollars.

Wherever at all possible, we prefer to give partial, rather than full, scholarships. It is our belief that some sacrifice on the part of the parents should be made for each student, the degree to be governed, of course, by the financial status of the parents.

To maintain a full scholarship for one student, it is estimated that a capital fund which would yield \$700 per year would be needed for each student.

(5) *Long-term needs.*—This program, because of the scope of its objectives, will ultimately be in the \$5 million range; this does not seem a disproportionate amount to spend on the education of the most promising youth of the Nation—and it is, of all amounts spent on education, probably the one most likely to return an overwhelmingly great benefit immediately and in the far-reaching future.

STATEMENT BY FRANCES G. KOENIG

American special education, because of its very nature, is involved in relations with many other professional and scientific fields. It overlaps other disciplines. The effectiveness of special education in the United States and its contributions to general education is determined in part by its very dynamics, its ongoing process; by its relationships with the interests, competences, and methods in general education.

Since we hope that our profession will continue to maintain itself as a "good" profession, we should be led to the formulation of action-relevant policies to guide us.

It is my belief that the Subcommittee on Special Education and Rehabilitation should concern itself nationally with acceptance of certain obligations:

1. Promoting research in special education and rehabilitation by emphasizing its importance in the training of teachers and counselors, in awarding scholarships and fellowships, and in professional advancement to the various colleges and universities with special educational facilities.
2. Developing sources of financial support for research.
3. Fostering the highest ethical standards in the conduct of research.
4. Inviting special educators as members of groups offering assistance to architects in the plans for school construction; convalescent homes, hospital classrooms; special equipment and other devices to aid the physically handicapped.
5. Setting the stage for classes for multiple handicaps, particularly the physically and emotionally handicapped, so as to bridge the gap between the physical and psychological in the special services required.
6. Offering scholarships to gifted physically handicapped young people with 120 IQ and over on State levels and being realistic concerning jobs and placement; job analyses to be made in advance.

RHODE ISLAND SCHOOL FOR THE DEAF,
Providence, R.I., December 23, 1959.

HON. CARL ELLIOTT,
Chairman, Subcommittee on Special Education,
House of Representatives, Washington, D.C.

MY DEAR CONGRESSMAN: It was with deep regret that I found it impossible to be present at the public hearings of the Subcommittee on Special Education in New Haven on December 18.

I earnestly request passage of House Joint Resolution 494, "Title I, Training of Teachers of the Deaf"; "Title II, Training of Speech Pathologists and Audiologists."

With reference to "Title I, Training of Teachers of the Deaf," the basis for this request can best be stated in terms of need. According to the American Annals of the Deaf for January 1959, page 156, the period 1958-59 shows a marked increase in the number of pupils and teachers in schools for the deaf as compared to the period of 1947-48. At the same time, the number of properly trained teachers failed to meet the needs. For example, a survey during the school year 1958-59, made by members of the staff of the Clarke School for the Deaf and the Hearing and Speech Center at Gallaudet College, indicated a need for over 500 trained teachers, while only 126 trained teachers were available.

Turning now to "Title II, Training of Speech Pathologists and Audiologists," we find an even greater need. According to the December Journal of the American Speech and Hearing Association, 32,000 trained speech pathologists and audiologists would be needed to meet the needs of speech and hearing handicapped children and adults in the United States. At the present time there are only about 7,000 available. It is further estimated that 1,500 clinicians should be trained each year to fill the needs, while actually only 400 are available from 70 schools.

If funds could be made available for this training, it would seem reasonable to assume that more individuals could be persuaded to enter this important field of education.

Very truly yours,

JOHN YALE CROUTER, *Principal.*

PSYCHIATRIC CLINIC FOR CHILDREN, INC.,
STAMFORD HOSPITAL,
Stamford, Conn., December 18, 1959.

HON. CARL ELLIOTT,
*Chairman, Subcommittee on Special Education,
House of Representatives, Washington, D.C.*

DEAR CONGRESSMAN ELLIOTT: As a clinic providing individual psychiatric treatment for emotionally disturbed children we have many occasions to call upon the services of trained special education teachers. The severe types of personality disturbance treated at this clinic frequently involve related handicaps such as cerebral damage, defects of hearing, vision, and speech, as well as specific and general learning disabilities.

While we are proud of existing facilities and the cooperative way in which available services are given, there are times when the lack of a needed special service has limited our effectiveness in treating the problem. Here are a few examples of problems which we cannot now adequately treat because of the lack of specialized services:

I. Arthur began to show behavior problems when he entered school. His problems were aggravated by a concussion which reduced his effective intelligence from the superior to the average level and left him so out of control that the neurologist who referred him said, "I worry that this boy may kill his father." This boy was given every advantage of our team psychiatric treatment approach and developed inner controls as well as the incentive to cooperate and learn.

Two years following discharge from our clinic, this boy has not made educational gains appropriate to his ability because he requires a special educational approach which has been found effective in dealing with cerebrally damaged children. He is becoming increasingly frustrated with his academic failures and may in time give up at school.

II. Roger is a 10-year-old boy of dull normal abilities who has no basic personality defect. However, he was referred to us by the school because the

teacher "could not reach him." When we studied this child we found he was deeply affected by his school failures and had given up trying to please his teachers. We found he was attending school in an area where nearly all of the children had high average to superior ability. We were told that he was too bright for a special class, although he is hopelessly behind his classmates. Roger's problem was of a kind which we frequently have referred to us. We recommended instruction by a specially trained teacher in a classroom with other children close to him in ability. The school would like to have such a program but sees no hopes of instituting such a classroom in the next few years. The use of our diagnostic service for Roger and others like him is actually a waste of our time since additional special class teaching could prevent his type of problem from occurring.

III. Peter is a 15-year-old boy of average intelligence who was referred to us as a learning and behavior problem. Although he was in seventh grade he could not reliably identify the letters of the alphabet. He has been seen by us for nearly 3 years. In connection with treatment we recommended individual help from a remedial reading teacher but learned that the school does not have enough of these specialists to provide individual help. We found a kindly Sister in a Catholic school who, while untrained in remedial reading instruction, offered to help Peter. We worked out a special school program for Peter and with treatment he began to demonstrate such superior mechanical skills that his shop teacher hopes to sponsor him as a special student at the technical school. He now reads at a third grade level. We felt that earlier attention to his reading disability could have prevented his serious emotional problems from developing.

Such problems as I have mentioned are educational problems frequently found in association with severe emotional problems. In order for treatment to be effective we must often coordinate our treatment with the services of an appropriate specialist. Since so much of today's planning is in terms of reaching the greatest number of children, I would like to point out that a number of professional people are giving intensive service to individual children and are often handicapped by the shortage of individually available special education services.

Thank you for this clinic's opportunity to voice our views. We feel that Federal support of programs to train and place special education teachers is necessary in order to stimulate communities to think in terms of making wider use of these services.

Cordially yours,

GEORGE W. SHULTIS, Ph. D.,
Chief Clinical Psychologist.

FAIRFIELD, CONN., PUBLIC SCHOOLS,
December 30, 1959.

Representative DONALD J. IRWIN,
House Office Building,
Washington, D.C.

DEAR MR. IRWIN: I am writing to you at the suggestion of your secretary, Miss Gleason. I spoke to her on December 18 and she in turn spoke to you about my interest in Senate Joint Resolution 127. Title II of this resolution provides funds to encourage and facilitate the training of speech pathologists and audiologists.

This legislation is needed because—

1. There is a desperate shortage of qualified personnel. Please note qualified means those who can work independently at the level of advanced certification with at least a master's degree.

2. There are 9 million Americans of all ages suffering from speech and hearing disorders, as summarized in this table:

Estimated incidence and prevalence of speech and hearing problems among United States 1960 population (continental United States, Alaska, Hawaii, and Puerto Rico)

	1960 population	Incidence, speech problems	Prevalence, speech problems	Incidence, significant hearing problems	Prevalence, significant hearing problems
Under 5 years (continental United States).....	21, 019, 000	<i>Percent</i> 1.3	262, 737	<i>Percent</i> 0.3	63, 057
5 to 19 years (continental United States).....	49, 782, 000	5.0	2, 489, 100	.7	348, 474
Over 19 years (continental United States).....	110, 353, 000	3.0	3, 310, 590	2.1	2, 317, 413
Alaska, Hawaii, and Puerto Rico (total all ages).....	3, 000, 000	3.4	102, 000	1.5	45, 000
Total.....	184, 154, 000	-----	¹ 6, 164, 427	-----	² 2, 773, 944
Grand total (speech and hearing).....	-----	-----	-----	-----	8, 938, 371

¹ Speech.

² Hearing.

3. Thirty-two thousand speech pathologists and audiologists are needed to properly diagnose, train, and rehabilitate our speech and hearing handicapped.

4. At present, there are only 2,000 certified speech pathologists and audiologists and some 5,000 noncertified specialists to cope with this handicapped population.

5. In order to cope with the critical shortage of trained personnel, universities should be graduating at least 1,500 trained speech pathologists each year. We are graduating only 400 each year.

6. The need for speech pathologists and audiologists is great in all States to staff schools, hospitals, and community service centers. In our own State of Connecticut, qualified personnel is not available to fill existing vacancies, or to permit needed expansion of present program.

Title II of Senate Joint Resolution 127 may be summarized as follows:

1. This legislation is proposed to make available funds with which to encourage and promote the advanced training on a graduate level of speech pathologists and audiologists.

2. The bill will result in funds for teaching, equipment, and fellowships for graduate students in speech pathology and audiology.

3. The Director of the Office of Vocational Rehabilitation, in cooperation with the Advisory Committee on Speech and Hearing Disorders, will establish and conduct this grants-in-aid program.

4. The grants-in-aid will be made only to institutions of higher education that prepare students to qualify for advanced certification in speech pathology or audiology.

5. The amounts of the stipends will be determined by the Director. It is expected that they would approximate those awarded under the National Defense Education Act.

You will note that there is a title I (training of teachers of the deaf) and a title II (training of speech pathologists and audiologists) in this legislation. Although I am primarily concerned with title II, I am naturally interested in seeing the entire bill passed.

I believe this legislation has been introduced in the House as House Joint Resolutions 488 and 494, and I think it deserves your sponsorship and active support. I would like very much to meet you and discuss this further, and answer any questions you may have about the work of a speech pathologist or audiologist. I can arrange to meet you at your convenience whenever you are in Connecticut.

My husband and I have followed with interest your election to and your activities in Congress. We have been impressed by your newsletters with their clear explanations of the positions you have taken, and we appreciate your concern for the plight of the New Haven's passengers.

The speech and hearing handicapped need your help too.

Sincerely,

LOIS R. MAYPER, Ph. D.,
Associate Consultant, Speech and Hearing.

Mr. ELLIOTT. Now, as our hearings come to a close, let me express my very sincere appreciation to the members of the Subcommittee on Special Education generally and my special appreciation to the gentleman from Connecticut, Mr. Giaimo, in whose hometown these hearings have been conducted. Mr. Giaimo and his office staff have been most obliging and helpful in making the preparations for these hearings and in conducting them and his friends in the community have been most gracious to myself and other members of our party.

I would like also to express the thanks of the subcommittee to the members of our staff, Dr. Frampton, Dr. Gall, Miss Hartman, Miss Allen, and to our reporter, and a special note of thanks goes to Yale University for its hospitality to the subcommittee and its staff and for giving us the benefit of its rooms for conducting our workshop, which lasted 2 days. That is quite an asset, quite a help to the subcommittee. And then to the witnesses and friends and all, may I close by wishing you a Happy Yuletide.

(Thereupon, at 4:20 p.m., the committee adjourned.)

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SPECIAL EDUCATION AND REHABILITATION

HEARINGS

BEFORE THE

SUBCOMMITTEE ON SPECIAL EDUCATION

OF THE

COMMITTEE ON EDUCATION AND LABOR
HOUSE OF REPRESENTATIVES

EIGHTY-SIXTH CONGRESS

SECOND SESSION

ON

H.R. 1119, H.R. 3465, H.J. Res. 488, H.J. Res. 494

BILLS REGARDING THE FIELD OF SPECIAL
EDUCATION AND REHABILITATION

PART 3

HEARINGS HELD IN CULLMAN, ALA.,
JANUARY 27 AND 28, 1960

Printed for the use of the Committee on Education and Labor



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SPECIAL EDUCATION AND REHABILITATION

WEDNESDAY, JANUARY 27, 1960

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON SPECIAL EDUCATION OF THE
COMMITTEE ON EDUCATION AND LABOR,
Cullman, Ala.

The subcommittee met at 10 a.m., pursuant to call, in the Cullman County Courthouse, Hon. Carl Elliott (chairman of the subcommittee) presiding.

Present: Representatives Elliott, Green, Daniels, and Giaimo.

Also present: Representative Albert H. Quie.

Staff members present: Dr. Harry V. Barnard, research director; and Dr. Merle Frampton, director, Study on Special Education and Rehabilitation.

Mr. ELLIOTT. The Subcommittee on Special Education of the Committee on Education and Labor of the U.S. House of Representatives will be in order.

The Subcommittee on Special Education is pleased to have this opportunity to visit in Cullman, Ala. I am happy to be home, and I am sure that my colleagues of our subcommittee are happy to have this chance to visit our scenic north Alabama.

We are meeting here today to receive testimony from the public on the most urgent, unmet needs in the field of rehabilitation and special education, and to hear specific suggestions as to how the Federal Government may best aid the States and local governments in attempting to solve some of these problems.

Early in the 1st session of this 86th Congress, our committee was flooded with bills, more than 100 of them, seeking to get at the problems in these two fields of special education and rehabilitation. Our subcommittee, wisely, I think and I hope, decided to do a complete investigation into the whole field of these problems, as a basis for future legislation.

We have held hearings already in New York City, New Haven, Conn., and following these hearings we will go to New Jersey next month. Soon, thereafter, we will hold hearings in Portland, Oreg., and perhaps in California, in an effort to get a complete coverage of the viewpoints, and particularly the recommendations for improvements to be made by people who work in this field and people who observe the operations of existing laws.

We do invite several hundred persons who are interested in these fields to each of our hearings, and usually it turns out that we have 50 or 60 witnesses who appear to testify.

In these hearings here in Cullman, Ala., today and tomorrow, we expect to have about 60 witnesses, all of whom have notified us of

their desire to testify. Some of these witnesses are here now and others are on the way.

These witnesses will come here from the 14 Southern States, from Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

At this time I have the privilege of introducing to you the members of our Subcommittee on Special Education. On my right is Mrs. Edith Green, a Member of Congress from the State of Oregon, from the fine city of Portland, Oreg. Mrs. Green and I have served on the Committee on Special Education for several years now. I have had the fine privilege of working with her on many items of legislation.

The one that I like to think of particularly at this time is the National Defense Education Act which came from our committee. Under the National Defense Education Act today, 1,400 Alabama boys and girls are going to college with loans provided by that bill. About 101,000 are going to college in the Nation under loans provided by that bill. That is only 1 of the 10 sections of the bill.

On the right of Mrs. Green is Judge Dominick V. Daniels, a Member of Congress from the State of New Jersey. He came to Congress in this 86th Congress and has served on our subcommittee since he came to Congress. He was an outstanding judge before he came to Congress. I am sure I bespeak the sentiments of everybody here and all those who will be with us when I say that we welcome Judge Daniels and Mrs. Green to Cullman, Ala.

On the right of Judge Daniels is Congressman Robert N. Giaimo. Congressman Giaimo is likewise a Democrat, a Member of Congress from the State of Connecticut. He lives in the city of New Haven, Conn. We held hearings in his city in mid-December of this past year.

Another member of our subcommittee who will be here shortly, and who at this moment is entering the door, whom we are very happy to have after the experience of failing to get the plane that he was originally scheduled on, is Congressman Quie.

Congressman Quie is a member of the Republican Party, a Member of Congress from the State of Minnesota. He comes to join us for these 2 days of hearings on this subject matter that he and all our fellow subcommitteemen here are deeply interested in.

We truly hope that out of these hearings we may be able to develop a law that will be highly beneficial and useful.

Now I want to recognize the mayor of the city of Cullman, Ala., who has been very helpful to the members of the subcommittee in arranging these hearings, and who has cooperated with us and worked with us to the end of getting these hearings underway.

I recognize and introduce now the mayor of Cullman, Ala., Mayor J.W. Arnold, to say anything that he might care to say.

STATEMENT OF HON. J. W. ARNOLD, MAYOR, CITY OF CULLMAN, ALA.

Mr. ARNOLD. Mr. Chairman and members of the congressional delegation, it is indeed a privilege to have you visit our city. I want to extend a welcome to you.

We are a county of 50,000 friendly folks and business people. One thing that makes Cullman unique is that we have 7,000 individually owned farms. I think that is a record of any county in the United States. Most of these farms are owned by the individual people. They are thrifty people, a cross between the German immigrants and the Georgia, Mississippi, Louisiana, and Tennessee people who came into our county.

It is a privilege to have you people here to join in this hearing. I want to thank Congressman Elliott for bringing the hearing to Cullman. While you are here, we want you to make yourselves at home. Any way that I can be of assistance to you, please call on me.

Again I want to say how much I appreciate the honor of you folks coming to Cullman.

Mr. ELLIOTT. Thank you very much, Mayor Arnold.

Another one of my fellow farmers that I have the privilege to thank at this time for what he has done to help us get this hearing underway is the judge of this judicial circuit, Judge Kenneth A. Griffith.

Judge Kenneth Griffith has cooperated with us in getting these hearings arranged for Cullman, Ala. His cooperation has gone to the point of relinquishing to us today his courtroom after he had already scheduled a court hearing. Because of his cooperation, I want to express the thanks of this committee.

The judge is in our audience now. I will ask him if he cares to say a word to our visiting friends from the committee.

STATEMENT OF HON. KENNETH GRIFFITH, JUDGE, 32D JUDICIAL CIRCUIT, CULLMAN, ALA.

Mr. GRIFFITH. Mr. Chairman and members of the committee and their attachés, the visitors we will have with us these next 2 days, I take pleasure and it is a real privilege to have the opportunity to thank you for this meeting here in our midst. We are indeed proud to have you.

I know, Congressman Elliott, that you have some small inkling or idea of the high regard that the congressional district that you represent has for you, and more particularly the people of Cullman County. They hold you in high regard.

I say that unhesitatingly to your colleagues here. You have served faithfully and worked hard for the people of this congressional district and they appreciate it.

I know that the thing that brings this committee here today is a labor of love, because a nation that can produce Representatives that have the humanitarian touch in their heart that these committee members must have, as evidenced by their taking time out to go all over this Nation to inquire into the needs of the unfortunate people whom nature has marked, and try and help them help themselves, it must be a source of satisfaction to you in this kind of work.

Knowing you, Congressman Elliott, as I do, I know it must be a source of satisfaction to you to help these people help themselves.

While I was probate judge and ex officio juvenile judge of this county for some years, I know that I have worked with you in the field of educating our younger people to make better citizens of themselves. In that position I found that the field is great, it is broad,

and there has to be a lot of work done to straighten out and put these young people on the right path.

As for the afflicted, we can do no more for them than to see that they get an opportunity to compete with their fellow men in earning a living, being self-supporting. You can bring gladness to their hearts that way more than any other way that I know of.

The mayor said that we are a county of 50,000. I think the mayor is thinking about the last census. I think this census this year will give us around 60,000 people. Certainly the city has grown rapidly in the last 10 years.

We are mighty proud to have you here. The latchstring is on the outside to you. We want you to enjoy yourselves while you are here. Thank you.

Mr. ELLIOTT. Thank you very much, Judge Griffith, for those kind and encouraging remarks.

Now, my friends, we will proceed to call our witnesses, but before we do that I want to acknowledge the presence here this morning of Dr. Merle Frampton. Dr. Frampton is the director of a special study in this field that is being carried on under the auspices of our committee. He comes directly here this morning from Atlanta, Ga., where he has been holding a workshop for the past 2 days, and from which workshop there will arrive here in Cullman this afternoon 20 or 25 people who will testify as to the conclusions and recommendations that the workshop evolved in its studies.

We are happy to have you, Dr. Frampton.

Present also are members of our staff who work with us. I speak now of Dr. Harry V. Barnard, who will assist the committee and be of assistance to the witnesses in any way possible. He is the research director for our subcommittee. Here also I want to particularly bespeak the thanks of the subcommittee to Bill Jones of my hometown of Jasper, Ala., Floyd Lawson of Decatur, and Carroll Eddins of Cullman, who have worked with us faithfully for the past several weeks in the days of preparation for these hearings. These three gentlemen are present here today.

If anyone has any business with the subcommittee that we cannot transact right at this time, or if the press or radio people want to contact us, Mr. Jones and Mr. Eddins are here in the courtroom now and will be happy to serve in any way they can.

Our first witness today is Mr. Paul Roy Brown of Jasper, Ala. Mr. Brown is a former superintendent of education of Walker County, the county immediately to the west of us. He has also served as a rehabilitation officer for the counties of Walker, Winston, and Marion in this Seventh Congressional District of Alabama. He is now principal of the Townley Junior High School at Townley, Ala. He, through long training and experience as a classroom teacher, as the principal of a junior high school, as county superintendent of education, and as a skilled, efficient, and dedicated workman in the vineyard of rehabilitation, is highly qualified to bring testimony to us at this time. I am happy to welcome my longtime friend, Mr. Brown.

STATEMENT OF PAUL ROY BROWN, JASPER, ALA.

Mr. BROWN. Thank you, Congressman Elliott. I believe you have omitted the most important person in this house in your introductions, Congressman, one person, your wife.

What about that? I am sure the people would like to see her.

Mr. ELLIOTT. I will ask my wife, Jane, to stand.

I think I also failed to introduce my secretary, Mrs. Cora Marlowe, who has volunteered to work with our subcommittee during these hearings, because of the absence of Miss Mary Allen, the clerk of our subcommittee, who has been sick for the past few weeks.

—Mr. BROWN. Mr. Chairman and members of your committee, I am deeply grateful for the opportunity of testifying to some of our needs in the field of special education in our area. But before discussing a few points briefly, I should like to say that we are honored in that you are holding this hearing in this particular geographic location of our great Nation. We indeed welcome you.

Having served as a classroom teacher, principal, county superintendent of education in the neighboring county of Walker, and also as a vocational rehabilitation counselor, I feel that I might present to you briefly, as I see it, some of the needs in special education and rehabilitation.

First, there is a large backlog of rehabilitation cases who could achieve independent living through liberalized rehabilitation services. This would minimize the home and institutional responsibility. It would add dignity and economic security to the home and the community.

We are reaching a very few borderline cases. In the total field of special education and rehabilitation, a small percentage of the handicapped is being reached due to the following reasons: Not enough specialized teachers to meet the needs in these fields; too few teachers are being trained; sheltered workshops, diagnostic centers, and evaluation centers are limited and inadequate.

I am aware of the fact that in the last few years many of the phases in rehabilitation and special education have been improved to some extent. But in order to meet the needs more adequately, it is imperative that these services be broadened. I understand that out of your committee came the National Defense Education Act, which is proving to be a wonderful aid in educating our youth.

I hope that you will be able to formulate a bill for special education and rehabilitation that will be as effective.

Mr. Chairman, that is the gist of what I have to say. I believe you told me that you would like to ask me some questions concerning this field.

Mr. ELLIOTT. Mr. Brown, you served in the rehabilitation phase and have served in education for many years. Do I understand you to say that you feel that primarily the shortage in the field of special education, the field of educating people who have disabling handicaps, is in facilities and teachers? I believe that is the statement you made.

Mr. BROWN. I think that is one of the greatest needs, Mr. Elliott, that we have today—facilities, places to do something with these people when they present themselves for rehabilitation services, and trained people to work with them. Those two things are the most needed things, I believe.

Mr. ELLIOTT. That is true in rehabilitation and true in education as well, is it not, both phases of it?

Mr. BROWN. That is right. I think that the bill, the education bill, that has just been passed for aiding boys and girls to attend college

is doing a great deal, and within 5 years I believe you will see a lot of benefit come from that in our schools.

You will not have a statement from each State saying that your school is on probation because this person has been shifted over to the other field, from social science to chemistry, or something like that. You realize what would happen in a case of that kind, putting a person from social science into chemistry.

Mr. ELLIOTT. I gather from your testimony that you feel there is a great group of people that are not reached by the present rehabilitation laws because they are limited to rehabilitating people for full-time employment; that beyond that, in the twilight zone beyond that, is a large number of people who can be rehabilitated for what we might call independent living so as to free the institutions of the expense, in many instances, of care that goes with their program as we presently have it.

Mr. BROWN. Yes, Congressman. In a lot of cases when I served as rehabilitation counselor, we would encounter a patient, a client, and we could not serve him because of that fact. The home was involved and we could not work it out.

So I think that independent living, a law passed that would liberalize rehabilitation to where we could take in those cases, and to give an overall rehabilitation service to the family in order to make it possible to rehabilitate service to the family in order to make it possible to rehabilitate that person, is needed.

I will say that I do not believe there are very many people who are beyond some type of rehabilitation. I think there are very few because they can be rehabilitated mentally or they can be rehabilitated physically or from a vocational standpoint. There is some phase of it that they can be rehabilitated in.

Mr. ELLIOTT. I have heard it expressed in the last day or two that probably we are not reaching, because of the limitations of our present law, more than perhaps 25 percent of the handicapped people who could profit by rehabilitation services.

Mr. BROWN. Did you say we are not reaching 25 percent?

Mr. ELLIOTT. We are not reaching more than 25 percent of the total who can profit.

Mr. BROWN. I see a number of my friends here, rehabilitation counselors, who have had a lot of experience, but I think if we were to say we were reaching 25 percent I think they would challenge me on that.

There is one thing I would like to bring out, Congressman. We have been involved with rehabilitation in this light. We have to have—they do not tell us so, but we know that a rehabilitation counselor needs 80, 90, 100, or 120 rehabilitations a year to make it look good on paper.

When a rehabilitation counselor works with 100 people he is limited in the service that he can render that patient. There is a great deal more, such as writing up a report and assigning him to some particular place for training. There has to be a lot of counseling and guidance with working with his client to see how he is getting along. I think that our rehabilitation counselors are running into that.

That is what I ran into when I served Walker, Winston, and Marion Counties. It was just so big until you did not have time to work with all these people, the clients.

Mr. ELLIOTT. You had more clients, so to speak, than you had time, did you not?

Mr. BROWN. Yes. I doubt if we served over 2 or 3 percent of them, or something like that. That would be my honest opinion.

That seems mighty small, but I am putting it down to bedrock now. It was 3 or 4 percent, those that we could actually serve. Then there is a field, a multitude of people in this country, who have never heard of rehabilitation. They do not know about it. They are due it; they ought to have it. But it has not reached them yet.

As a matter of fact, we need more publicity. We are getting a lot of publicity, but even if they were to come in we could not do anything about it, because we have more than we can do anything with.

We talked a lot about referral. We would get up 300 or 400 referrals and put them in a card index. We are in such a rat race, if you will excuse that expression, that we never have any time to get back to the referrals. These that are before us, those are the ones we are working with. We need more rehabilitation counselors, more specialized teachers. The whole program of rehabilitation, I think, needs to be enlarged.

We are our brother's keeper. I do not believe anybody lives to himself or dies to himself. I think it is a wonderful thing for this committee to be here to look into the whole problem of special education and rehabilitation.

I think it is just in its infancy. I can visualize in years to come when rehabilitation will be so effective that you can see a great deal of differences in our local communities, our towns, and our homes, the effects of it.

Mr. ELLIOTT. Thank you very much, Mr. Brown.

Are there questions of the witness? Mrs. Green?

Mrs. GREEN. I do not have any questions.

Mr. ELLIOTT. Mr. Quie?

Mr. QUIE. I would like to ask one question, if I may.

Do you have a school or do you have training facilities in Alabama for the teachers of the deaf or for speech pathologists?

Mr. BROWN. Yes, we have some places that offer this teaching, this education.

Mr. QUIE. In Walker County, how many of your schools have a teacher for, we will say, the deaf or the speech handicapped? None whatsoever?

Mr. BROWN. We have what is called special education teachers from the schools that take the retarded children. But actually specialized teaching in that field we do not have.

Mr. QUIE. Do you have one resident school for the deaf in the State?

Mr. BROWN. In the State?

Mr. QUIE. Yes.

Mr. BROWN. Yes, we have one.

Mr. QUIE. That is all I had.

Mr. BROWN. Thank you very much.

Mr. ELLIOTT. Thank you, Mr. Brown.

Our next witness this morning is Dr. Robert C. Berson, vice president of the University of Alabama, in charge of the university's medical center at Birmingham, Ala.

STATEMENT OF DR. ROBERT C. BERSON, VICE PRESIDENT, UNIVERSITY OF ALABAMA MEDICAL CENTER, BIRMINGHAM, ALA.

Dr. BERSON. Thank you, Mr. Chairman.

Mr. ELLIOTT. We are happy to have you, Dr. Berson. You may proceed in any manner that you desire. The only limitation I have to impose is that with the number of witnesses we have we will be limited to about 10 minutes per witness. But if you have a statement in writing you can incorporate that into the record in full after you have made your statement.

With that, you may proceed.

Dr. BERSON. Thank you, Mr. Chairman.

Actually, I am deeply interested in the proposal of House Joint Resolution 494 for training of teachers of the deaf, speech pathologists, and audiologists, but I think you are going to hear from people in the next day or two who have more specialized knowledge in that field than I do.

The medical center tries to run a hearing and a speech clinic, so we have some firsthand knowledge of the shortage of trained people in this field. But I would like to address most of my remarks to the independent living provisions of H.R. 3465, and mostly to make two points about it.

It would be very difficult to overemphasize the importance that I attach to this measure if it is adopted. One of the points is the tremendous need for realistic support for programs of expert evaluation. Of course, my perspective is that of a specialized teaching hospital and its clinics.

Actually, when you first try to evaluate any severely handicapped persons, it is very difficult to be certain what are reasonable goals for the rehabilitation of that person until you have gone into the matter pretty carefully from the usual aspects of the counselor or the social worker, the psychologist, the specialists in several medical fields.

Sometimes the determination of realistic goals falls short of being fully employed in the usual sense. But that does not mean that the goals are not worthwhile, because the difference between being totally dependent and having to have a full-time attendant for everything, or being able to look after yourself, is a tremendously important thing to the individual, his family, and the community.

The saving in money that is accomplished when one person can be so improved that he no longer needs to be in an institution or no longer needs a full-time attendant, whether this is a paid individual or a member of the family, is a tremendous saving, because it is one that goes on month after month and year after year.

At the present time in the medical center we are in the early stages of planning an expanded rehabilitation program and facility, and this problem of the program being adequate to support the evaluation of patients is a difficult one until it finds some solution.

When we develop the program we expect, it will only be reasonable for severely handicapped people from all over the State to be sent there for evaluation and such treatment as should be given centrally. But for a great many of those people, it wouldn't be realistic to say that they can be so far rehabilitated that they can be fully employed.

So to go back to the beginning, it would be difficult to overemphasize the importance that I attach to this measure for the benefit of all the handicapped people and the people who are trying to help them.

Mr. ELLIOTT. Thank you, Dr. Berson.

Let me ask you one question: Do you train speech therapists at the university medical school?

Dr. BERSON. No, not in the medical center. I think perhaps some of the people from the main campus will be testifying later, and they can tell you in far more detail of their training program for teachers. But in the medical center we do not. We employ some. We have to have them.

Mr. ELLIOTT. You do not train what we call audiologists either, do you?

Dr. BERSON. No. We have to have them, too, but we do not train them ourselves.

Mr. ELLIOTT. Are there any questions of Dr. Berson?

Mrs. Green?

Mrs. GREEN. No questions now, Mr. Chairman.

Mr. ELLIOTT. Judge Daniels?

Mr. DANIELS. No questions.

Mr. ELLIOTT. Mr. Giaimo?

Mr. GIAIMO. No questions.

Mr. ELLIOTT. Mr. Quie?

Mr. QUIE. No questions.

Mr. ELLIOTT. Thank you very much for your testimony, Dr. Berson. It will be very helpful and we appreciate it.

Our next witness this morning is Mrs. Ethel Gorman, of the Social Hygiene & Mental Health Association, Birmingham, Ala.

We are happy to have you, Mrs. Gorman. You may submit your statement for the record, if you desire, and summarize it, or submit it in any fashion that you desire.

STATEMENT OF MRS. ETHEL GORMAN, SOCIAL HYGIENE & MENTAL HEALTH ASSOCIATION, BIRMINGHAM, ALA.

Mrs. GORMAN. Thank you. Mr. Elliott and members of the committee, I am going to discuss a different type of handicap than most of the people here.

Delinquency is a handicap which is often more devastating in its effects than physical or even mental handicaps, because it involves not only the individual and his family, but society as well. Because so little is known scientifically about behavior in general, and delinquent behavior in particular, rehabilitation efforts have largely failed.

Because of the irritating nature of this handicap, and because the rising rate of delinquency proclaims to all the world our failure to solve the problem, we react with anger. Instead of seeing the socially, emotionally, often mentally and sometimes physically handicapped individual, we are blinded by the glare of his melodramatic actions. His behavior is his handicap. His need for rehabilitation is not his need alone. It is the Nation's.

We think nothing of spending vast sums to try to put man on the moon, but if he doesn't learn how to get along with his fellow man

any better than he has in the past, are we not merely enlarging the territory for fear and unhappiness?

If comparable amounts of money were spent to learn how to modify human relationships—of which delinquency represents one of the most serious failures—think of the possible gains in happiness, security, and peace.

The goal of any rehabilitation program for delinquents is to modify behavior. Now, behavior is learned. Psychologists tell us that after a certain response to a stimulus has been established, it will take at least as long—and usually longer—to substitute a different response or behavior.

So we cannot hope for a sort of 3-minute child wash, where we can run through our delinquents and bring them out clean. Delinquents did not become antisocial overnight. They will not learn more acceptable behavior through quick "cures" like curfew laws, parent responsibility laws, more recreation, slum clearance, and the like. They will learn different behavior—if at all—by a slow, painstaking re-learning process.

If we take a blank piece of paper and crease it repeatedly in a crooked line, the crease becomes a habit of the paper, as it were, and the crooked line the habitual position of the paper.

To increase the paper so that the creased line is straight across the page requires even more effort than it took to fold the paper crooked. And some trace of the crooked line will continue to mar the page. But the line can be changed and that is the important point in the analogy to a child's delinquent behavior.

In Alabama there is no opportunity for a delinquent child to be taught new behavior on any consistent basis except perhaps at the Alabama Boy's Industrial School, the State Training Schools for Girls, in Birmingham, and the Alabama Industrial School for Negro Children at Mount Meigs.

However, their budgets are so low that they cannot take all the children who could profit from commitment, and at the Alabama Boy's Industrial School the constant pressure of new cases forces the release of many boys before they are ready or when they must return to homes which are so unsuitable that they tear down all the new behavior the children learned during their 8 or 9 months of discipline. The rate of recidivism has increased in the last 5 years from 11 to 23 percent.

The training schools are now getting the most confirmed delinquents, and those are the hardest to change. Knowing about the shortage of space, committing courts have a tendency to wait until the child's position is critical before sending him. This may have a bearing on the recidivism rate.

Still another influence may be the fact that the average IQ rate at the school is between 75 and 80, which is far below the norm of 100, and a parolee under 16 years, and most are 15, has no alternative but to return to a schoolroom which offers only abstract learning, academics beyond the boy's ability and usually association with children younger and smaller than he is.

His feeling of frustration and inferiority overwhelms him and in anger he strikes back blindly at society, first in truancy, then often by running away, stealing, or assault. So the State's investment in his

training is lost. Once more the public yells "Get tough," behaving toward him, the delinquent, exactly as he has behaved toward the public and for the same reasons: bewilderment, frustration, anxiety, inadequacy, and the resultant anger.

But suppose that, upon release, those boys who are uninterested in or incapable of academic work had a place to go where they could receive job training. Mr. J. S. Hill, superintendent of ABIS, stated that 100 percent of the institution's population could profit from some type of job training. Perhaps only about 20 percent could learn such highly skilled vocations as automobile mechanics, printing, and the like.

The majority of the boys—75 percent—could learn such trades as painting, paperhanging, bricklaying, and similar occupations which require manual dexterity and concrete, rather than abstract, learning. Even the very slow children—5 percent—could learn simple, routine jobs and the habits and attitudes which would give them some possibility of graduating into paid helpers on farms or on assembly lines.

Experts on mental illness emphasize the fact that the inmate of an institution is taught to adjust to institutional life, rather than to community life. Upon his release, he is convalescent, just as a patient is who has been hospitalized for physical illness; the difference being that the family and community has in the past expected the mentally ill person to come out of an institution fully "cured" and able to fit immediately into the pressures and demands of daily community life.

This country has been building halfway houses in order to provide a stepping stone from the institutional life to community life, in order to let the patient learn community skills and practice them again.

The same concept seems valid for the delinquent. He, too, in a "reform," industrial, training or whatever-you-choose-to-call-it school, learns to adjust to institutional living, which is quite different from community living. I submit that the same concept of a halfway house for delinquents would be a valid step toward easing them through the critical postinstitutional period. This is the time when most recidivism occurs.

So, then, if there were a residential facility with group therapy or counseling, casework service and job training, we might see a significant reverse in the present trend toward increasing recidivism.

But such a facility need not be limited to parolees. There are many boys known to juvenile court who could be placed directly in such a facility without the necessity for commitment to ABIS, or who could remain in their own homes while participating in the work training and counseling program on an outpatient basis. Such a facility would decrease the pressure on the State correctional institution, perhaps enabling it to do more thorough and successful work with the children they receive.

A study of the incidence of delinquency in Jefferson County during a 5-year period from 1952 to 1957 revealed a case increase of 40.59 percent, while the juvenile population increased only 16.54 percent. The most marked rise occurred in the case of Negro males, which went up 57.25 percent during the period.

Approximately 75 percent of the children were between 12 and 15 years old. The percentage of increase in the number of repeaters

rose from 32.8 among white children in 1952 to 39.9 in 1958, and from 39.8 among Negro children in 1952 to 43.5 in 1958. Clearly, the tide of recidivism is rising and at the moment overburdened probation officers cannot stop it. Clearly, something new must be tried.

The public school is not meeting the needs of delinquent children, or even of those handicapped in a less alarming way. Birmingham and Jefferson County probably have more special classes than other parts of the State, but in Birmingham there are 300 children on the waiting list for a special class and only 448 so placed. Of these classes, only two true junior vocational classes are offered, although there are some scattered vocational courses in several high schools.

Since 20 percent of Birmingham and Jefferson County's school population of 121,278 have IQ's in the 73-91 range, we can estimate that 6,063 children in this area fall into the group of slow learners which makes up the bulk of the present delinquency population. No attempt is made to offer special education or attention to the so-called borderline children, who are not retarded enough to be eligible for the special classes, or for the delinquent child.

The public has been slow to recognize that it has as much responsibility to train and rehabilitate the child with a behavior disorder as it does any other handicapped child. School personnel often reject the responsibility because they think it belongs to the home; the home has usually rejected the responsibility before the child got to school.

Therefore, we must consider not so much whose responsibility it is as who will assume it, because somebody must. We must not put ourselves into the self-excusing category of a father in our county who complained bitterly after his fourth son got into trouble: "They just raise kids different nowadays." "They," he said.

The Vocational Rehabilitation Service seems most suited of all existing agencies to assume the responsibility for job training of delinquents. I therefore propose that the law governing the categories of handicapped people that this agency may service be amended to include those with behavior handicaps.

I further propose that funds be made available for a 3-year pilot research and demonstration project, to be located in Birmingham, Ala., to determine the effect of a residential work training and counseling facility upon the rate of delinquency recidivism in the area.

Mr. ELLIOTT. Thank you very much.

Are there questions of Mrs. Gorman?

Mrs. GREEN. Mr. Chairman, first of all I think she would make a superb witness for other legislation also before the committee.

I take it from your testimony that you are suggesting that some of those who are mentally retarded and have other handicaps are more likely to become delinquents?

Mrs. GORMAN. It is the borderline group, I believe. It is in our county. I know there are some national studies that say that is not true, but in our county we find that they are between 73 and 91, the majority of delinquents. That is borderline. It is slow, but not retarded.

Mrs. GREEN. Between 73 and 91 percent of the delinquents?

Mrs. GORMAN. No; the IQ.

Mrs. GREEN. The 73 to 91 IQ?

Mrs. GORMAN. The majority of delinquents are in that IQ range.

Mrs. GREEN. Are there any authoritative studies in Alabama that would show the percentage of the mentally handicapped or the low IQ's who become delinquents in comparison to the population as a whole?

Mrs. GORMAN. I do not believe there are any authoritative ones. I base it on the boy's industrial school average. Of course, they get commitments from all over the State. The average IQ of the boys committed there, and they test all the boys there, is between 75 and 80. That comes from the school.

Then at juvenile court there is no actual scientific research which has been given to the subject. I suppose it really would be guesswork. But just from observation you know that the majority of children are in the borderline group.

Mrs. GREEN. Perhaps a future witness should be asked this question, but some time ago in the paper I read a report that a very large percentage of those who were handicapped as far as hearing was concerned had been automatically classified as mentally retarded, and further tests showed that it was not a mental retardation but, rather, a partial deafness.

Do you know of any such studies?

Mrs. GORMAN. No. I know it happens, but I do not know of any study in Alabama.

Mrs. GREEN. That is all, Mr. Chairman. Thank you.

Mr. ELLIOTT. Are there any other questions of this witness?

Mr. DANIELS. Mrs. Gorman, you suggested a halfway house for these delinquent children. Could you give us some more specific details of your recommendation?

Mrs. GORMAN. Yes. I would suggest it would be more permissive than a training school. It would be set up, I should think, a little bit on the order of the Hifelds plan, only I think not in the country, but in the city. I know a lot of people think that the CC camp idea would be better. But personally, I think they have to learn how to live in the city if they are city boys.

I would suggest that they would live in a home with house parents and with casework service available. I would think some sort of group therapy would occur, which would take a trained person to do, in the evenings. The job training would come in the daytime, I should think, and the group therapy at night. Then I would like to see them placed on jobs eventually.

Mr. DANIELS. Would you detach a delinquent boy from his family and send him to a foster home? Is that your thought?

Mrs. GORMAN. I was getting away from the foster home idea, because I do not think most delinquents can accept the foster home and certainly very few foster homes will accept a delinquent, or a teenager. Most foster parents would take smaller children and are not interested in delinquents.

I think delinquents and most adolescents get along better in a group, anyway, with their peers. I think they would accept being away from home in a group better than they would accept a foster parent.

Mr. DANIELS. That is all. Thank you.

Mr. GAIAMO. These recommendations that you make in order to seek a solution to this problem of delinquency, do you feel that it can only be accomplished if there is Federal participation?

Mrs. GORMAN. Well, of course, if Vocational Rehabilitation comes in on it, the law would have to be amended, because at the present time they cannot accept a delinquent unless he is disturbed mentally or retarded.

Mr. GIAMMO. I am talking about the delinquent. You are suggesting an amendment to the law to include the delinquent. My question to you is: Is there a necessity of Federal participation in this field of the delinquent or should this problem be handled at the State level?

Mrs. GORMAN. Well, that remains to be seen about the money, I suppose. I am in the process now, or we are in Jefferson County, of organizing a citizens committee. It has been organized and it is attempting such a program. However, I do not know whether the money will be forthcoming.

Unless we had somebody to teach for the job training part of it, it would be lost anyway. It seems to me that the vocational rehabilitation people already are skilled in that particular area. I am sure they would need more workers assigned if they are going to take that on, too, but they would be the natural people to carry forward such a program, I should think.

Mr. GIAMMO. Thank you.

Mr. ELLIOTT. Mr. Quie?

Mr. QUIE. Have you tried or are you using the visiting teacher in Birmingham?

Mrs. GORMAN. Yes; we have visiting teachers.

Mr. QUIE. How is that working? Has it cut down the juvenile delinquency, the use of the visiting teacher?

Mrs. GORMAN. Well, I do not know that it has. Facetiously, it adds to the burden at juvenile court because about, I should say, 40 percent of the children brought in are for truancy. Well, maybe not that high, but a large percentage of the children brought to juvenile court are for truancy. I know I used to see children brought in for truancy, I would have them tested, and they would turn out to be quite retarded or they would turn out to be borderline children who could not keep up with the schoolwork.

Are you going to say a person is delinquent because he does not want to go someplace where he does not understand what is going on? I guess it is yes and no. They probably keep some out, but I do not know.

Mr. QUIE. Then I gather that the biggest problem causing the delinquency is the retardation and the people in rehabilitation would be more qualified to handle that than the visiting teacher, just changing the social arrangement in the family?

Mrs. GORMAN. Much more. The idea of job training, I think, is important. So many of these children who go into schoolrooms have never been able to learn. Even when they have a normal mentality, most delinquents have reading problems.

It seems that they have concrete learning ability, but not abstract learning ability. I do not know why this is. Perhaps that is one thing that needs some research.

Mr. QUIE. Thank you.

Mr. ELLIOTT. Thank you very much, Mrs. Gorman.

I have a statement from Alabama's senior U.S. Senator, Lister Hill, together with a letter addressed to me under date of January

25, 1960, expressing his regrets on being unable to appear before this subcommittee today, and forwarding a statement on the matters now pending before this subcommittee.

The statement of Senator Lister Hill will be made a part of the record at this point.

I also have a telegram dated January 26, yesterday, from Alabama's Senator John Sparkman, which states:

Wish very much I could be with you at the hearings relating to the handicapped. You, your subcommittee, Dr. Frampton, and other expert witnesses are to be commended most warmly for your interest in and your efforts to be helpful to those unfortunate groups. Their handicaps, though, need not be completely incapacitating. Many can be rehabilitated to useful and independent living with proper care and attention.

For many years I have worked for legislation and other measures designed to benefit our disabled children and adults. I served on the President's Committee To Employ Physically Handicapped, so my interest is of long standing. We owe these citizens a chance to overcome their difficulties and to make the fullest contribution possible to society and to the welfare of the Nation.

I pledge you my full cooperation to this end.

JOHN SPARKMAN,
U.S. Senator.

(Senator Hill's statement follows:)

STATEMENT BY HON. LISTER HILL, U.S. SENATOR FROM ALABAMA

Mr. Chairman and members of the subcommittee, it was with the greatest pleasure and deepest interest that I received your kind invitation to submit this statement to the Subcommittee on Special Education of the Committee on Education and Labor in the course of its study on special education and rehabilitation.

Before offering specific comments, I should like to express my gratitude to the chairman and to the subcommittee for what I consider an excellent contribution to the whole field of study of special education and rehabilitation. I refer to a compilation of Federal resources and services in these fields which will soon be published by this subcommittee. This will be the first time that we will have in one volume an inventory of all Federal agencies that deal with these matters—and a listing of the services each provides. This inventory will be of great assistance to all Members of the Congress as we consider ways and means of improving special education and rehabilitation with a minimum of duplication.

I should like also to compliment the entire subcommittee on the way it has gone about its business of studying its assigned fields. The subcommittee is following a practice that I consider to be in the highest tradition of our democracy; it is taking the problem to the Nation and gathering in all major geographic areas of the country the opinions, beliefs, facts and other information that will be of assistance in drafting legislation in this field.

The subcommittee's sessions in Cullman are a fine example of the process of going to the people with problems that concern all the people. And I may say that no part of the country could be more appropriate than Cullman and its surrounding trade area for any study of rehabilitation.

Here is a region that has lifted itself by its own bootstraps and the wisdom and energy of its people into a model of progress for most sections of the South and of the whole Nation.

To me, one of the outstanding programs of service to our people consists of the program of vocational rehabilitation of disabled people. I have watched with the greatest gratification as this program has progressed in most of the States throughout the Nation. It was a pleasure for me to lend my active support to the enactment of a new vocational rehabilitation law in 1954 that has enabled the States and the Federal partner in this cooperative endeavor to accomplish, if not miracles, at least wonders of progress.

I have seen four major bottlenecks that hampered and slowed rehabilitation in the States, if not completely broken at least opened to the point where the hindrances to progress have been minimized. Both the States and the Federal Government have more than doubled their contributions since 1954, thus removing the drag of an insufficiency of vital financial support. The total State moneys devoted to rehabilitation this year exceed \$31 million as against \$13.8 million

in 1954. Meanwhile the total Federal funds, most of them for the support of State programs, have risen from \$23 million in 1954 to \$64.6 million for the current fiscal year. As chairman of the Senate Appropriations Subcommittee having jurisdiction over the rehabilitation appropriations, I have taken great satisfaction in insisting on adequate funds for this vital program. You may be sure that in the future I will continue my efforts to increase Federal funds available for this important work.

During this period I have seen the number rehabilitated so that they may secure employment advance from about 55,000 in 1954 to 81,000 during the past fiscal year, and the number of individuals receiving rehabilitative services that ultimately will restore them to independence increased from about 200,000 in 1954 to more than 300,000 during the fiscal year just past.

Secondly, there has been well opened the bottleneck of inadequate trained personnel to carry on the expanding nationwide program.

This forward stride is being accomplished under a program of training grants for which authority was incorporated into the 1954 legislation. During the past fiscal year the Office of Vocational Rehabilitation made 197 grants to colleges and universities for the training of more than 1,000 skilled professional workers who can handle the intricate jobs of advising and counseling disabled men and women and youth, of handling their psychological, medical, and vocational problems—so that they may become independent, self-supporting, contributing citizens.

A third bottleneck that is being opened under the vigorous administration of research authority is that of inadequate knowledge of advanced techniques, of problems of employment and of better methods of handling various severe disabilities so that their victims too can make their comeback. There were more than 200 projects of this nature underway last year and 42 of these were selected demonstration projects in areas of severe disability—projects in which newly won information gained through research is being given practical application in meeting the problems of disabled people in all parts of the country.

Fourth among the bottlenecks was a shortage of facilities. This is being met head on, both through the provisions of the vocational rehabilitation law and through an extension of the Hill-Burton survey and construction program. Under the Vocational Rehabilitation Act's provisions, 94 rehabilitation facilities, sheltered workshops, and visual aid centers were established or substantially improved last year, while under the Hill-Burton program, 114 comprehensive rehabilitation facilities had been approved through 1959.

From the foregoing, it is obvious that the entire vocational rehabilitation program has been making commendable progress, both at the Federal and the State levels.

We have now come to the point where existing rehabilitation legislation does not meet the complete needs of our Nation. One of the more glaring shortcomings of our existing rehabilitation program is that, worthy as it is, we stop now with help for those who seek help only for the purpose of obtaining work. This is the program that I have extolled on many occasions, as I have done in this statement. But we should not stop with rehabilitation to employment.

There are literally hundreds of thousands of disabled people in our country who can return to self-reliance through rehabilitation services even though they may not have bright or immediate prospects of employment. These people cannot be served under existing rehabilitation laws.

There is a great need for us to widen the scope of existing programs in order to make it possible for such people to receive rehabilitation services that will enable them to achieve the fullest possible measure of independence, whether this be in meeting the activities of daily living or in working at a job as well.

It is an established fact that disability and disease are major causes of dependency and thus are a drain upon our economy. Prolonged disability wipes out family income and savings and sometimes forces families to break apart, destroys essential work skills, brings on public assistance and institutional care with its burdens on the public and their lack of satisfactions for those forced to accept such aid or care. Meanwhile the Nation's productivity suffers and, worse, our people thus afflicted are bereft of their pride, dignity, and joy of being self-sustaining citizens.

To substitute positive remedies for these defects in our national health pattern, I have introduced in the Senate a bill that, when enacted, will provide rehabilitation services for independent living. A long list of distinguished colleagues have joined with me in sponsoring this legislation—S. 772.

It is with greatest gratification that I call to your attention the fact that Chairman Elliott has introduced an identical bill in the House—H.R. 3465.

I shall not detail the provisions of the bill since they have been incorporated in the report through a previous hearing and workshop of the subcommittee, but I should like to state generally what these bills would accomplish.

The bills first would assure the use of all Federal moneys appropriated for extension and improvement of the State programs of vocational rehabilitation, whereas some States today fail to use this money while other States could effect profitable improvements if they had more funds. So the bills permit the transfer of unused money from one State to another that needs and has use for it.

Secondly, the bills would provide for appropriations and give authority for the rehabilitation of disabled people to independent living. This provision for rehabilitation to independent living will prove a boon to our people who, in an ever-increasing population of older people, are beset with chronic illnesses that accompany advancing years and for many others, regardless of age, who suffer disabling conditions by reason of illness or injury. It is my conviction that this is an increasingly needed service of our people and that, in the long run, it will enable many to return to work even though their present prospects seem poor. I am certain also that, in the long run, the bills will save public funds—in the cost of institutional care and other public assistance. But above and beyond all of that, I value the social and humanitarian gains that will accrue.

That provision is the core and heart of the bills and its aim would be effected through amending the current Vocational Rehabilitation Act.

There is a mounting need for workshops and rehabilitation facilities that not only would contribute to independent living but could serve as means of part-time, limited, or other employment for many who now must remain in enforced idleness while their capabilities are dissipated through disuse. This need is much larger than the public knows and our bills make ample provision for a start toward remedying these shortcomings in our present rehabilitation programs. There is plenty of leeway given for tailoring the facilities to the need. For instance, Cullman or Jasper might need a small sheltered workshop or rehabilitation center, while larger cities like Birmingham might need a much larger facility.

Of tremendous importance is the evaluation of disabled people's actual condition, their rehabilitation needs, their work potential and all the other factors that go to compose that most intricate work of God—the human being. Provision for such evaluation in all States is contained in our bills and they would apply to even the ultra-severe disabilities such as paraplegia and quadriplegia, epilepsy, emotional illness, and all of the others.

Our bills also would make it easier for research institutions to undertake studies in rehabilitation techniques and other problems relating to disability by eliminating as a condition for receipt of a research grant the requirement that the institution defray a part of the cost. While many medical schools and other institutions might be willing to do the work essential to solving a specific problem, they might not be able to pay a portion of the cost. Since solution of these problems is pertinent to the conduct of our public rehabilitation programs, it seems a deterrent to ask them to pay for any part of research costs.

Equally pertinent to the deliberations of this subcommittee are identical bills which Mr. Elliott and I have introduced to help resolve a very serious problem affecting 30,000 deaf children of school age in the United States and the 8 million Americans who suffer from serious speech and hearing impairments.

For purposes of identification, my bill is Senate Joint Resolution 127 and Congressman Elliott's bill is House Joint Resolution 494.

The problem which affects our deaf children lies in the critical shortage of teachers specially trained to educate such afflicted children. To meet the educational needs of these children, who, of course, have the same aptitudes and intellectual potentialities as have children with normal hearing, we should be graduating 500 teachers of the deaf annually. Instead of 500, we have less than 150 in training this year. Six of the institutions accredited for the training of teachers of the deaf do not have a single student enrolled for training this year. The situation is critical and it is national in scope.

The problem adversely affecting those 8 million Americans who suffer from speech and hearing impairments of such a nature as to seriously handicap many of them in their efforts to become independent, self-supporting, taxpaying members of their communities, is an identical one. We need many more specially trained persons to diagnose and correct speech and hearing impairments and to train and rehabilitate the afflicted.

The joint resolution would establish parallel programs in the Office of Education and in the Office of Vocational Rehabilitation which, through the grant

mechanism, will, I hope, encourage a sufficient number of young people to undertake training to become teachers of the deaf, or to prepare themselves to treat and rehabilitate persons with speech and hearing impairments. The numbers of individuals involved in these programs would be relatively small and the cost, estimated to be less than \$3½ million a year, would be far less than the dividends which would be paid to the Government as a result of these programs. These dividends to be gained from the development of the abilities of those afflicted with speech and hearing impairments or deafness would include not only increased strength and productivity for our Nation but dividends in dollars—in the increased tax returns which would be paid by the many thousands of individuals who, as a result of these programs, would become independent rather than dependent, employed rather than unemployable, taxpayers rather than tax consumers.

In conclusion, I wish to thank Mr. Elliott and the other members of the subcommittee for this invitation to submit my statement on these matters. I certainly hope that your labors will result in beneficial legislation.

Mr. ELLIOTT. Our next witness this morning is Mr. John C. Harmon, Jr., special assistant, Goodwill Industries of America.

May I say we are happy to have you, Mr. Harmon. You may proceed with your testimony at this point.

**STATEMENT OF JOHN C. HARMON, JR., SPECIAL ASSISTANT,
GOODWILL INDUSTRIES OF AMERICA, WASHINGTON, D.C.**

Mr. HARMON. Thank you, Chairman Elliott and members of the committee.

As an attorney in this atmosphere, I feel like saying "Your Honor and members of the jury."

I have a prepared statement which I shall not read, but place into the record.

I would simply say this: that we in the operation of sheltered workshops believe that perhaps the most important thing in dealing with disability and the problems of handicaps which come from those disabilities is that of how one has a fair chance at the starting line.

We believe that starting line is at the employment office. We sympathize with the personnel director, or whoever it is, that is seeking to employ people. For example, here are five people who are interested in a job. There are two jobs available. It is obvious that one of these persons has some kind of disability. How this affects his skill, this employment officer is not sure. He has two jobs. He is very likely to fill those two jobs with the people that he thinks will be less trouble because he is thinking about the foreman that he is going to send this man out to, and the foreman is going to say, "Listen, I haven't got time to find out what this man can do."

So we believe that the sheltered workshop is the spot at which we determine not the disability, not the handicap, but the abilities that this person has.

Someone has said that many of us have numerous skills. Some of us have perhaps only one skill. If we can match that skill with the skill of the job, then we have done the job.

Here in the South, amid the developments that have taken place in agriculture and in industry, where we have people who live with one foot on the land and one in the plant, we in Goodwill Industries

are tremendously concerned about how we reach these people who are in our rural sections as well as in our cities across the country.

It is a pleasure to be here. There is much I would like to say. As you know, the best way we think for you to see the problem is to visit our Goodwill Industries across this country wherever you have an opportunity. Our people will welcome you.

Thank you.

Mr. ELLIOTT. Thank you, Mr. Harmon.

I would like to ask you a question, Mr. Harmon: Is the Goodwill Industries idea growing very rapidly in the rural sections of the country at the present time?

Mr. HARMON. It is growing. You see, we come at it in a very pragmatic method. We go out there and pick up material. A contributor who contributes material to the Goodwill Industries is apt to say "Just a minute. You say you have a program to serve handicapped people." So they are apt to speak to friends who do come in. Transportation has aided this.

Some of the plants are placed on the edge of a town so that they come in from distances. The Cincinnati Goodwill Industries is a good example of a regional plan to reach all the people across a wide sector of the country.

I would say that we are making some progress. But to those that are closest to it, sometimes it is most frustrating that we cannot make more progress and quicker.

Mr. ELLIOTT. Thank you very much, Mr. Harmon.

Are there further questions of Mr. Harmon?

Mrs. GREEN. No questions, Mr. Chairman, but I certainly would personally testify to the tremendous contribution the Goodwill Industries makes in my own city of Portland in this field.

Mr. HARMON. Thank you.

Mr. ELLIOTT. Thank you very much, Mr. Harmon.

(Mr. Harmon's full statement follows:)

STATEMENT OF JOHN C. HARMON, JR., SPECIAL ASSISTANT, GOODWILL INDUSTRIES OF AMERICA, WASHINGTON, D.C.

Mr. Chairman and committee members, my name is John C. Harmon, Jr. I am here representing the 25 local Goodwill Industries located across the 14 States covered by this hearing today.

I am special assistant to the executive vice president of Goodwill Industries of America, Inc., of which these Goodwill Industries are members. As a native of North Carolina, I am glad to have this opportunity of speaking on behalf of the cause of rehabilitation in the South.

It gives me great pleasure to extend on behalf of not only the Goodwill Industries located in the South, but also for the other 95 Goodwill Industries in other parts of the Nation, our deep appreciation for the interest shown by this committee in the cause of the handicapped. Especially we would commend its chairman for his most able and dedicated leadership.

We believe the role of the sheltered workshop in the field of rehabilitation is most important. Goodwill Industries, since its beginning in 1900, has sought to minister to the needs of both the physical and spiritual in man. We serve all types and degrees of disability. There is no age limit in fact, about 15 percent of the people we serve are over 65 years of age. Because this has always been a practical program, we have tried to keep it in step with the changing needs of the local community. This calls for a comprehensive rehabilitation program in one community and a small sheltered workshop in another place. Our goal is always a job which brings the independence, self-assurance, and dignity that man deserves. A person may enter a Goodwill Industries for evalu-

ation services as a client from another voluntary agency or from the State vocational rehabilitation agency or the Veterans' Administration. It may be training for a specific job is needed. In some cases, the disability may be so severe as to preclude normal competitive employment. But in each case, the goal is still the same—normal employment.

In the South, as elsewhere, disability has been radically affected by the tremendous strides forward in medicine and surgery, psychology and social science. We need but mention the great progress being made in the treatment of some of the disability conditions * * * cardiac surgery, mental retardation, diabetes, blindness, paraplegia, epilepsy, Parkinson's disease, and mental illness. Where persons once died, they can now live. But with it all comes a greater challenge to rehabilitation. We must aid these and others to overcome disability to live an independent, useful, self-respecting way of life. We must have the adequate treatment of the disability but there must be follow through in evaluation of abilities * * * follow through with prevocational services, with basic training to a goal wherever possible of gainful employment.

Great progress has been made by both voluntary and governmental services that these goals be reached. But, we in Goodwill Industries know we have only just begun to meet the challenge.

We wish to point with pride to the voluntary efforts of citizens in the local community which have produced the largest group of sheltered workshops in the Nation under the slogan "Not Charity * * * but a Chance." But we know this is not enough. Right here in the South amid such phenomenal growth in business and industry, we have only 25 local Goodwill Industries. We salute the progress of workshops operated by other agencies. Yet, all this is not enough.

All this preferred form of voluntary effort at the local community level has not been enough. There has to be a close partnership with the agencies of government both Federal, State, and local.

The action of the Congress in creating Public Law 565 has played a major role in the expansion and growth of Goodwill Industries. This has been especially true here in the South. Twenty-two of the twenty-five Goodwill Industries located here have received grant aid under this law during the past 5 years. We wish you and each Member of Congress could visit each of these 22 sheltered workshops and see the progress made. We wish it were possible here to tell about it in detail. We can only cite an example or two.

A Goodwill Industries was started in St. Petersburg, Fla. with the aid of a Federal grant under section 4(a)(2) of \$21,912 in 1956. A great deal more than the necessary matching funds of \$10,956 was raised by the community. The fruits of this incentive grant have not ended. We can say that last week there were 176 people in this sheltered workshop receiving services they otherwise might not have secured. Tax takers are now tax payers.

A Federal section 4(a)(2) grant to the Winston-Salem Goodwill Industries of \$9,824 in 1957 created such a revival of concern by the community that by the end of this coming summer, a new million dollar rehabilitation center and sheltered workshop will be completed. Only 3 years ago it was a small workshop serving less than 60 people. The \$50,000 in Hill-Burton funds made this possible with the balance raised by voluntary community effort. It is a fine tribute to the distinguished leadership of the Senator from Alabama, Lister Hill.

In the Memphis Goodwill Industries a demonstration project with the cerebral palsied has been started this year under section 4(a)(1) of Public Law 565. We hope to here learn more that will extend the services of sheltered workshops in a very needed area.

This "seed" money has worked wonders * * * But it is not enough. The main source of this aid, section 4(a)(2) expired in 1958. It is more urgently needed now than ever.

A recent survey of Goodwill Industries revealed that for every person served, at least one has to be turned away because there is no available place. Just yesterday, I was told by the executive director of the Atlanta Goodwill Industries that they had a waiting list of over 400 persons.

We just have not kept pace with the great strides in industrial development in the South. Even an enlightened management alone cannot employ enough of the handicapped. Prior evaluation, vocational training, and trial employment is needed to close the gap between hospital and factory.

Right now there is need and interest to start new sheltered workshops in at least 14 cities across the South. It is a proven fact that Federal incentive grants

can be put to no better use than to encourage the establishment of sheltered workshops in these cities because Goodwill Industries are so largely self-supporting after establishment and so practical in their services. We are glad the chairman of the committee, Representative Bennett of Florida and other Members of the House and Senate have already introduced bills which meet this need. The study of this committee will be most valuable in placing before the Congress a comprehensive picture of the entire field of special education and rehabilitation. But we in Goodwill Industries would hope that some way be found to provide assistance during the interim for the imperative need now. It could take the form of the old section 4(a)(2) with any necessary changes. We in Goodwill Industries do not wish to lose any of the momentum already gained in establishing sheltered workshops across the South.

The accelerated services provided by both Government and voluntary agencies have made it possible for business and industry to employ disabled persons in ever-increasing numbers. Again it must be realized that this success makes the task for the future more difficult but certainly not impossible. We now find in Goodwill Industries persons coming for service with an increasing severity of disability. This means that the modern workshops must furnish evaluative adjustment and training services. For example, the mentally retarded require not only expert medical diagnosis but specialized services for evaluating their work potentiality. This evaluation can best be provided through psychological tests and try-out in a job situation within a sheltered workshop. Not only in mental retardation but in the case of other disabilities, normal living is expedited in a situation calling for emphasis on productive cooperation and personal responsibility. At the same time this deemphasizes the limitations and the "patient" role of the client, while stressing the worker productivity role in society. All this requires well-trained staff personnel. This includes first-line supervisory personnel. It requires more modern tools and working conditions that best create the job atmosphere and skills for tomorrow's employment.

We know voluntary support at the community level will rise to the challenge. But we know that the task is so big that it requires the maximum cooperation of both the voluntary agencies and the Government. We believe the working partnership between Goodwill Industries and the State and Federal vocational rehabilitation agencies will continue to grow and improve. This requires enlightened leadership at the local community level, in the State legislature, and the Congress. It calls for increased recognition on the part of labor and management that the services of the sheltered workshops must receive their wholehearted support. "We employ the Handicapped" becomes a living slogan with the effective use of the sheltered workshops as a midway testing and training ground. Above all we need an awakened people everywhere that it is ability that counts, not disability.

Mr. ELLIOTT. The next witness will be Mrs. Grady W. Jones, of Jasper, Ala.

STATEMENT OF MRS. GRADY W. JONES, JASPER, ALA.

Mrs. JONES. Federal financial support of education is an American tradition.

George Washington in his first message to Congress said:

There is nothing which can better deserve your patronage than the promotion of science and literature.

Thomas Jefferson urged the appropriation of public lands for the support of education.

The Ordinance of 1887, in order that "The means of education shall forever be encouraged," provided for grants of Federal lands to States, income from which is still supporting education in every State in the Union.

Education is not solely a local and State responsibility. Thirty-two million Americans changed community residence in 1957. Over 5 million changed State residence. A child poorly educated in one is a social or economic liability to every State and the Nation.

Authorities estimate that 10 percent of Alabama's school-age children are in need of treatment for speech and hearing problems. Approximately half are suffering with impairment severe enough to require extensive therapy and specialized speech teachers.

Impairments which are corrected at the early stage of schooling and even before school age will mean much to the economic and social future of the children, as well as the community at large. With specialized training and treatment, they can be an asset to community life, earning their way as they reach adulthood. Otherwise, they could be a burden on society and welfare rolls. The most important needs in this program are:

- (1) Teachers who are professionally trained to teach exceptional children.

- (2) Professional personnel, particularly psychologists, required for scientific screening and evaluation of the mental ability of these children.

- (3) Physical, occupational and speech therapists for children in physical handicapped classes. We have 544 crippled children in Walker County.

Indeed, we must have Federal aid to put on a successful program. I was informed that in the whole State of Alabama we have only 307 special classes. Of the 307 classes, 220 are serving mentally retarded.

In Walker County we have only four mentally retarded classrooms. Three of these are in white and one in colored. Of course, many more of these are needed, and specialized teachers for them. We have only one class that offers speech therapy.

We in the South realize the great needs in many phases of education, but can see for the first time in 100 years for abundant living and genuine economic prosperity on the horizon. The signs are everywhere: The additional appropriations for education during the recent special session of our State legislature; the magnificent contribution by Congressman Elliott, Senator Hill, his committee and others in setting up a desirable program in higher education, special education, and rehabilitation. And why should we not have confidence?

Dr. Frank A. Rose, president of the University of Alabama has said:

It is my belief that in the next 15 to 20 years Alabama can become one of the 10 most prosperous States in the entire country. It is quite possible that in only five States—New York, Pennsylvania, Texas, Illinois, and California—will the standard of living exceed our own.

The statements would have seemed unrealistic only a very few years ago. These changes have been brought about by the untiring efforts of our great leaders. We, as citizens of the South, must grasp our opportunities fully.

Bill 3465 aims to fill the gap in rehabilitation legislation so as to assist the States in providing for their handicapped citizens, greatly improved programs for the evaluation of rehabilitation potential, rehabilitation services for severely handicapped persons who can profit substantially from such services but may not achieve vocational rehabilitation and facilities wherein evaluation services and rehabilitation services may be provided.

We do have rehabilitation agencies in this State and other States to provide evaluation services for applicants for vocational rehabilitation but not for individuals whose objectives are less. Of course, most people believe that evaluation is the weakest link in the present vocational rehabilitation programs.

Last year in Walker County the expenditures for old age and the welfare payrolls almost equaled the total budget for our education for all the boys and girls of the country. Some of the people on the welfare payrolls might be able to earn their own living if they were given an opportunity to learn a trade or would be acceptable under the independent-living bill.

On December 22, 1958, a small facility was opened in Jasper. It is designed to serve applicants for vocational rehabilitation, but not for individuals whose objectives are less. It is designed to serve qualified handicapped adults in Walker, Winston, and Marion Counties. It provides diagnostic and evaluation services, vocational adjustment, vocational training, limited work employment and cooperative job placement and job followup. We are real proud of our beginning and we feel that filling in the gaps in rehabilitation legislation will greatly improve our program.

Our rehabilitation counselor, Mr. I. J. Pesnell, and his staff are doing a wonderful work with their limited funds and limited facilities. He contacts approximately 1,200 clients per year. Of these, there are very few that qualify under the present setup.

There are three main qualifications one must pass before he can be accepted in this facility:

- (1) The presence of a physical or mental disability and the resulting functional limitation or limitations in activities.

- (2) The existence of a substantial handicap to employment caused by the limitation resulting from such disability.

- (3) A reasonable expectation that vocational rehabilitation service may render the individual fit to engage in competitive labor.

In this area we need a much larger facility and provision made for those handicapped individuals who cannot be absorbed in competitive labor markets.

I think that the independent living rehabilitation services will greatly improve our vocational rehabilitation services, particularly for the most severely handicapped. As you know, our different agencies already have an effective working agreement with the medical and other professions that will provide independent living rehabilitation services.

Educators need to encourage our young people to train to become physical therapists, occupational therapists, speech therapists, and other professions required in our rehabilitation programs. We need to acquaint our young people of grants that may be obtained.

Mr. ELLIOTT. Thank you, Lorene, very much for that fine statement.

Mrs. Jones has been in the very forefront of interest and activity in this field, about which she speaks so well, in my hometown, in my home county. I appreciate the fine service and leadership she is giving. I appreciate her interest and her testimony.

Are there any questions of Mrs. Jones?

Mrs. GREEN. Mr. Chairman, I would like to say to Mrs. Jones and Mr. Brown that I am personally delighted to know a couple other leaders from Jasper. We think we have an active and good chamber of commerce in Oregon, but I want you to know that in Washington you have a one-man chamber of commerce for the Seventh Congressional District, and I have yet to see its equal.

This is my first trip to Alabama, and one of the things that I wanted to find out was that if half of the stories that Carl Elliott told us about the Seventh Congressional District are true, you should be competing successfully with all of your Texas friends.

Mrs. JONES. We are very proud of him and all of them.

Mrs. GREEN. You should be.

Mr. ELLIOTT. Are there any other questions of Mrs. Jones?

If not, thank you again, Mrs. Grady Jones.

May I say that Mr. Earl York, the county superintendent of education of Cullman County, has been here for some time this morning. He tells me that he will be with us again and that we will see him later today.

Our next witness is Dr. Jack Rosen, director, New Orleans Speech and Hearing Center, New Orleans, La.

Mr. Rosen, we are very happy to have you here in Cullman, Ala., and we look forward to your testimony. You may proceed.

STATEMENT OF JACK ROSEN, DIRECTOR, NEW ORLEANS SPEECH AND HEARING CENTER, NEW ORLEANS, LA.

Mr. ROSEN. Mr. Elliott and members of the subcommittee, in testifying before you, I intended to speak primarily on my own behalf as one who has studied the needs of children and adults with speech or hearing defects, worked with persons with communication handicaps, taught undergraduate and graduate students in audiology, and administered clinical and training programs in this field.

As executive director of the New Orleans Speech and Hearing Center, I speak for members of its board of directors and its staff. The Louisiana Speech and Hearing Association has appointed me chairman of a committee to support the passage of your bill, House Joint Resolution 494, and for its several counterparts in either House.

Since accepting your invitation, I have also been asked to represent the Otolaryngology Department and the Speech and Hearing Center of Tulane University Medical School.

I believe that my views will in general reflect the principles and views of the American Speech and Hearing Association, the American Hearing Society, and other professional and lay societies interested in the prevention, solution, or alleviation of these terrible handicaps.

Unlike the dramatic killers, such as poliomyelitis, cancer, circulatory diseases, and automobile accidents, speech or hearing defects do not kill their victims. Nevertheless, the victims are just as surely handicapped and just as surely crippled psychologically, educationally, socially, and vocationally.

Unlike blindness, cerebral palsy, and many orthopedic handicaps, the handicaps of speech or hearing have received comparatively little organized publicity to arouse the sympathies and support of the public.

In fact, deafness and speech deviations are among the few handicaps which are still fair game for comic treatment, thus increasing the difficulties in habilitating or rehabilitating the targets of ridicule. Unlike many with severe mental retardation or psychosis, multiple sclerosis, and other neurological or psychiatric disorders, most persons with speech or hearing handicaps now are good prospects for rehabilitation which will permit them to function as breadwinners, church and family members, and complete citizens.

Surveys elsewhere in the Nation have led to the estimate of 8 million Americans whose speech or hearing defects are severe enough to handicap them. On this basis there are likely to be at least 150,000 such individuals in Louisiana.

When geographic, economic, and cultural factors are taken into account, the probability is that this estimate errs conservatively. Aside from the upper respiratory infections which cause many ear pathologies and consequent hearing losses in humid coastal areas, we have a peculiar hereditary pattern of deafness in an area of several parishes—counties—of our State.

Louisiana has excellent speech and hearing clinicians who are equal in training and experience to any comparable group in the Nation. Unfortunately, their number is so few that they must function with the constant frustration of knowing that they are unable to serve the vast numbers who need their services.

Four hundred speech pathologists and audiologists are needed here. The current membership of the Louisiana Speech and Hearing Association is only 36, and there are 35 associate members, most of whom are undergraduate or graduate students. An individual's competence in this field is recognized by one of several certifications granted by the American Speech and Hearing Association.

Of the 36 members, 24 have basic certification in speech, 4 have provisional basic certification in speech, and 7 have achieved advanced certification in speech. In hearing there are only two with basic certification and one with advanced certification.

The picture becomes darker when we find that several of the 36 qualified persons are either out of the State, inactive professionally, or engaged in other pursuits.

Serious shortages of speech and hearing clinicians exist in all parts of the country, but Louisiana and other States in the southern region are undoubtedly affected most severely by the shortage. Fully half the present number in Louisiana who hold advanced degrees in speech and hearing are from regions outside the South or have had to go outside the South to obtain their advanced study.

In order to fill the most urgent job openings for persons with advanced training, it is necessary to entice competent persons from all sections of the country. This is not easily done by programs which have limited budgets and which must attract clinicians from areas where similar openings and opportunities exist aplenty.

The passage of House Joint Resolution 494 and its Senate counterpart, Senate Joint Resolution 127, for grants-in-aid to graduate students and financial assistance to training institutions will decrease the enormous gap between the needs for and the availability of well-trained speech and hearing personnel. Minor controversies regarding the assignment of administrative responsibilities should not be

permitted to delay or interfere with passage of this urgently needed measure.

It should not be overlooked that speech pathology and audiology have responsibilities for the rehabilitation of the millions of adults of all ages with difficulties in communication, as well as for the children who need our services. It is quite fitting that the Office of Vocational Rehabilitation, which has several years of experience in the administration of training grants and other assistance to this field, be charged with the responsibility given it under title II of your bill. House Joint Resolution 494 is a major step in the right direction, and I urge its passage upon all Members of the House of Representatives.

In addition to House Joint Resolution 494 and Senate Joint Resolution 127, the Congress can foster the development of speech and hearing facilities in other ways. Others have voiced the need for aid to the establishment or expansion of centers for the evaluation and rehabilitation of the hard of hearing, the deaf, the speech handicapped, and those who fail to develop language or speech.

New centers are needed in some areas, but many communities throughout the Nation have speech and hearing centers, clinics, or hearing societies. Most of these operate on a private, nonprofit basis with the support of united funds, community chests, universities, civic organizations, and private benefactors.

In view of the personnel shortages, new centers will have to take trained personnel from existing centers which can ill afford to lose their staffs, employ inadequately trained personnel, or lie idle during the several years of anticipated personnel shortage. Wherever a center exists, therefore, priority should be given to assisting the existing speech and hearing center to expand its facilities, to acquire modern electronic and electro-acoustic equipment, and to add to its staff.

Each staff member added to an existing speech and hearing center increases the efficiency and economy of its services to the handicapped. New graduates from our training institutions will gain the valuable experience of working in established programs under the supervision of more experienced persons in the field. Eventually, externships should be established in such centers for the professional experience which should precede unsupervised professional work.

The needs of the speech and hearing handicapped can further be served by the encouragement of research. Fundamental research in communication, audition, and in the physiological and psychological processes involved will continue to contribute mightily to our ability to grapple with the imposing and often mysterious ailments with which we contend. However, basic laboratory research in itself does not supply knowledge which we can apply directly in the clinic, nor is this its purpose.

In fact, there is an enormous gap between the data supplied by laboratories and the applicability of such data to clinical problems. Applied research, best done by clinicians who know the problems firsthand, is needed to determine the applicability of the vast data available and also to suggest specific topics for laboratory exploration.

Highly trained clinicians in speech pathology and audiology are able and eager to explore the complexities of communications problems in the children and adults with whom they work. They find it extremely difficult to obtain the necessary financial support for such

explorations unless engaged in basic research in university laboratories or in Federal or State agencies.

I urge that restrictions be removed from future grants by the National Institutes of Health, the National Science Foundation and other public agencies in order that private, nonprofit agencies may conduct practical research in existing speech and hearing centers on clinical subjects readily at hand. Such a policy would multiply our research results with minimum expenditure of public funds.

Mr. ELLIOTT and members of the subcommittee, thank you for providing this opportunity to express these special needs in the fields of special education and rehabilitation of the hearing and speech impaired. All who work in this and related fields, and all the handicapped and their families will appreciate your efforts.

Our sincere hopes go with you that your efforts and ours will alleviate the distress of millions of people throughout the Nation.

Mr. ELLIOTT. Thank you very much, Mr. Rosen. Are there questions of Mr. Rosen?

Mrs. GREEN. How many institutions are there for training teachers for the deaf now?

Mr. ROSEN. There are no institutions for training teachers of the deaf in Louisiana.

Mrs. GREEN. How many are there across the country? Do you know?

Mr. ROSEN. This is difficult to say, because there are opposing schools. There are some which still adhere to old methods, in which the so-called combined training is used, that is, the use of finger spelling and speech, and others which concentrate on the development of speech and lip reading that is normal, oral communication.

Somehow it is difficult to combine the figures for the two types.

Mrs. GREEN. I notice in House Joint Resolution 494 it says, "Whereas at least six of the institutions accredited for the training of teachers for the deaf have no trainees enrolled for the academic year"—why is this, when you have six institutions?

Mr. ROSEN. Teachers of the deaf receive the same salaries, as a rule, as teachers of regular classes. This is also true of speech and hearing therapists in the public schools. Nevertheless, although their salaries are the same, they are required to have additional training, usually training on a graduate level.

In fact, from the speech pathologist's and audiologist's point of view, unless they do add graduate work, they really are not truly qualified. For them to afford this additional graduate training requires a special dedication, since their rewards after they graduate are not going to be any greater than those of regular classroom teachers.

Mrs. GREEN. What will title I accomplish if we already have six institutions that are fully accredited and then under title I, section 101, the Federal Government would establish and give some grants-in-aid to public and nonprofit institutions if we cannot get the trainees? Why go on with the program?

Mr. ROSEN. Title I provides for assistance to students, to graduate students. We believe that this assistance to graduate students will require this additional training and may encourage students who otherwise would not be able to proceed further with their studies.

In that case, the six institutions with no trainees would soon have trainees.

Mrs. GREEN. As I understand it, it would be grants-in-aid to the institution in covering the cost of the program.

Mr. ROSEN. I am not as familiar with title I as with title II. I know that in title II, and I thought in title I, there was the direct aid to students as well as to the institution.

Mrs. GREEN. My point is if we have the institutions and they are already set up to go ahead and we do not have the trainees, we are not going to do anything by just giving more money to them from the Federal Government; are we?

Mr. ROSEN. That is probably correct.

Mrs. GREEN. All of the emphasis would have to be on paying higher salaries to the individual or to pay for fellowships.

Mr. ROSEN. Graduate fellowships first, under title I, I imagine. Under title II, however, I believe that the two forms of assistance are needed immediately.

Mrs. GREEN. I notice in this bill they use the same figure you have used, 8 million Americans suffering from speech or hearing impairments. How did you arrive at that figure?

Mr. ROSEN. These estimates are based upon surveys done in several communities and in a few larger areas within several States and are derived also from the accumulation of figures of the White House Conference of 1950, I believe.

Mrs. GREEN. How do you get the figure of 20,000 speech pathologists and audiologists being needed?

Mr. ROSEN. Approximately 1 to every 400 who need their services. This, by the way, on a clinical basis, is far too great a caseload. This is the caseload frequently among public school speech and hearing therapists.

For the person who operates in a clinic or hospital and who does largely work with individuals, rather than groups, the average caseload would more likely be 50. Therefore, the number of speech pathologists and audiologists needed is also a conservative estimate.

Mrs. GREEN. For my own information, could you answer the question I directed to one of the previous witnesses on this study which I have read about, that many of the mentally retarded were diagnosed wrongly and that it actually was a speech or hearing impediment? Is there such a study?

Mr. ROSEN. I know of no formal studies that have shown this, but all of us in the field have experienced many incidents of this sort. The fact is the incidents work in both directions. We also have many hard of hearing and deaf children supposedly who are really mentally retarded.

Mrs. GREEN. This is my point.

Mr. ROSEN. It works both ways. In the institutions for the mentally retarded there are some people who would not have been there if the diagnoses had been correct early enough. We are particularly concerned about early diagnosis of very young children to determine if this is hearing loss, mental retardation, certain forms of brain damage or certain forms of psychic disorders. This is one of our major functions.

Mr. DANIELS. Do we have a sufficient number of teachers to train people in speech therapy and audiology at the present time?

Mr. ROSEN. We might say that we do, if we rob Peter to pay Paul. The problem is that the same people who are well trained to teach are also well trained to do the work. They always have the problem of deciding where to place their efforts.

For example, in the past I was professor of speech and hearing at Western Reserve University in Cleveland, at which time a major portion of my work was devoted to teaching, to teaching audiology. Today a major portion of my work is in administering and doing clinical work, administering a clinical program and doing clinical work.

I have the choice of which I can or would do. I cannot devote full time to each, although sometimes I feel as if I am doing that.

Mr. DANIELS. Then as I review your testimony, we will have a problem getting sufficient teachers to go into these particular fields to train the necessary personnel?

Mr. ROSEN. I believe an adjustment will occur.

Mr. DANIELS. An adjustment of salary?

Mr. ROSEN. Yes. That is, when the institutions have assistance to conduct their training programs, they will be able to attract people not just on the basis of salary, because salary has not always been a primary goal of people in our field. We are quite young and most of us still feel the strong air of dedication.

I think also the possibility of a flourishing training program with associated research programs will attract people to the universities as well as some increase of salary. The salary would not hurt, of course.

Mr. QUIE. The six schools, or institutions, that are spoken of have no trainees enrolled at the present time? Do they teach the new or the old system? Do they teach the use of sign language for teaching the deaf?

Mr. ROSEN. There will be a witness this afternoon who represents the Louisiana State School for the Deaf who is a teacher of the deaf. I am not. I would much prefer that the questions in that area be directed to her.

Mr. QUIE. Do you think there are sufficient school facilities now for training of teachers of the deaf and for speech pathologists, but just that we need some stimulus to bring more people into the program?

Mr. ROSEN. There is a great enough number of institutions with training programs; yes, I would say. Of course, if we discover that people start flocking to our field, we may find that we do not have enough. But at the present I would say that there is a great enough number. The problem is in encouraging the development of programs that exist.

Mr. QUIE. Is it not also true that many times teachers of the deaf, anyway, and perhaps teachers of the speech-handicapped, are actually paid less than comparable teachers in the public schools?

Mr. ROSEN. In some cases I believe in residential schools part of their salary is given them in the form of housing and meals. This might be considered as less salary. There may be some private schools where the salary scales are lower than the public school levels for regular teachers, but as I said, in that area, too, I am not as well versed as I should be.

Mr. ELLIOTT. Thank you very much, Mr. Rosen.

Mrs. Westmoreland, consultant in special education, Texas Education Agency, Austin, has telephoned that she cannot be present due to illness.

We have eight or nine witnesses to hear before lunch, and I will have to say that, as much as I hate to do it, we must limit our witnesses to 10 minutes.

Next we will hear Mr. William J. Miller, Florida Rehabilitation Association, Tallahassee, Fla.

Mr. Miller, if you have a written statement, you can submit it for the record or summarize it.

STATEMENT OF WILLIAM J. MILLER, FLORIDA REHABILITATION ASSOCIATION, TALLAHASSEE, FLA.

Mr. MILLER. Thank you.

First, I would like to thank you, Congressman, and the rest of the committee, for the opportunity of coming here and meeting with you and discussing the problems and needs of the handicapped people, and convey to you greetings from our board of directors.

I was instructed to urge passage of the independent living bill as has been presented to Congress in H.R. 3465. Some of the reasons that we feel that this is needed in Florida are as follows:

In 1954, when Public Law 565 was passed, it broadened the scope of our service and enabled many demonstration and research projects to go on. This enabled the rehabilitation agencies in the State to handle a group of people that, prior to this time, they had been unable to rehabilitate vocationally.

It also indicated that, or told us, that we still do not know the potential of people that can be rehabilitated vocationally. But we did find a large group of people who needed other services in order to live independently.

We know that in nursing homes and in our communities there are a large number of individuals who need personal adjustment services in order to be independent and not have someone taking care of them; that this not only is expensive, but it is only humanitarian and sound that these people be offered some opportunity to live independently.

The Florida Legislature, last year, passed an enabling act so that the division of vocational rehabilitation could provide independent living services. This was passed after the present law had been introduced in the Congress, and primarily would enable us to take advantage of such a law if it were passed.

At the hearing conducted by the committee in the passage of this bill, there were representatives from the public and private agencies, representatives of the medical profession who had been working with the division of vocational rehabilitation. This bill passed unanimously both houses of the legislature last year.

We feel that postponement of the passage of the Federal act would deter the rendering of services to a large number of people that need this service now, and that the money that is in this bill in Congress probably is about enough to start some demonstration projects in various States as to what really can be done in providing independent living services and would give some idea, probably, of the cost of this program.

We would like to urge that H.R. 3465 be passed as early as possible. That is all I have.

Mr. ELLIOTT. Thank you very much, Mr. Miller.

May I say to you, Mr. Miller, that your written statement will be made a part of the record immediately following your oral presentation, if you desire.

Mr. MILLER. That will not be necessary, Mr. Chairman.

Mr. ELLIOTT. Are there any questions?

If not, thank you very much.

Our next witness is Dr. Arthur H. Dohlstrom, professor of mental health, University of Alabama School of Nursing, University, Ala.

STATEMENT OF DR. ARTHUR H. DOHLSTROM, PROFESSOR OF MENTAL HEALTH, UNIVERSITY OF ALABAMA SCHOOL OF NURSING

Dr. DOHLSTROM. Mr. Chairman, members of the committee, ladies and gentlemen, originally I was invited here as a member of the American Association for Gifted Children, but I should much prefer, if I may in this very brief time, to talk about all children and all people who need help in special education or in rehabilitation.

In my contacts throughout the State, and they have been quite varied because of my position and my previous positions as a consultant, I have found a high degree of interest, a very fine awareness, and a great, intense desire to do the very best job that can be done in both of these important fields.

However, I also find that the lack of trained personnel is the most serious detriment that we have in the State of Alabama. When I talk of trained personnel, we have real shortages in all of the fields that have direct contact or should have direct contact with these people.

Other witnesses have mentioned the need of therapists, physiotherapists, occupational therapists, speech therapists, social workers, nurses, psychologists. You name them and we need them, and we need them badly.

I would like to make the strongest possible bid for your serious consideration and support of traineeships and fellowships for the training of the necessary personnel.

I have found also throughout our State a very fine spirit of cooperation, people working together so well. I think if we had the people, the personnel, to do this important job, we could be way high on the list of any of these 50 States in the end result of what we would hope to accomplish.

I might mention to you the three fields wherein I have had some intimate acquaintanceship—social work, psychology, and nursing. We have found that one of the better ways of getting people to work in these important areas in Alabama is to get Alabamans to have the opportunity of going away to school and then come back and do the job here at home.

I make this plea for the traineeships and scholarships that will enable our people to do this.

In the area of vocational rehabilitation, one of the greatest needs as I have seen it has been for perhaps a more intensive and prolonged diagnostic evaluation of the people who are in need of the services and

then continued therapy and further evaluation as they go through the rehabilitation process.

I think it would be extremely helpful to us here if we had some funds available that would permit the establishment of new facilities rather than merely the extension or the refurbishing of some of the present ones. We are badly in need of facilities, too.

I have made my two strongest bids. I would like very much, if I may, to answer questions in the brief time we have left.

Mr. ELLIOTT. Are there questions of Dr. Dohlstrom?

Mrs. GREEN. You have said there is a great dearth of adequately trained personnel in many, many areas, and certainly in the field of nursing, itself, there is a dearth of graduate nurses.

Are you suggesting that perhaps this is not the right approach, for instance in 494, to train teachers or to pass legislation for the training of teachers for the deaf?

Dr. DOHLSTROM. No. They have great needs, and this is one of our important areas. The president of the school is attempting to do a job with the people we have. When I said the training of teachers, this starts at the university level.

In the College of Education at the university, we have openings where it is not possible to get the people to come to teach the teachers.

Mrs. GREEN. But you would like trainees and fellowships in many areas besides the training for the deaf?

Dr. DOHLSTROM. Yes.

Mrs. GREEN. In other words, you would like a more comprehensive program.

Dr. DOHLSTROM. Definitely.

Mrs. GREEN. Can you tell me if the American Medical Association has taken action on either of these bills, either the Alabama Medical Association or the national?

Dr. DOHLSTROM. The "doctor" stands for a Ph. D. in clinical psychology and I cannot answer for the American Medical Association.

Mrs. GREEN. You have no knowledge of their position?

Dr. DOHLSTROM. No, ma'am; I do not.

Mr. ELLIOTT. Are there any other questions of Dr. Dohlstrom?

If not, thank you very much, Dr. Dohlstrom. Your testimony has been very helpful and we appreciate your kindness.

Dr. DOHLSTROM. Thank you, Mr. Elliott.

Mr. ELLIOTT. Our next witness is Dr. Thomas S. Gibson, of the American Optometric Association, of Huntsville, Ala.

Dr. Gibson, will you give us a word of background and then proceed in any manner you desire?

STATEMENT OF DR. THOMAS S. GIBSON, AMERICAN OPTOMETRIC ASSOCIATION, HUNTSVILLE, ALA.

Dr. GIBSON. Thank you, Mr. Chairman. I shall do so, sir.

My name is Thomas S. Gibson, and I live in Huntsville, Ala. That is the rocket city and also the hometown of Senator Sparkman.

I have practiced my profession of optometry for the past 20 years. I am here today representing the American Optometric Association, of which I have been an active member for the past 20 years. I have served as president of the Alabama Optometric Association, and as a member and president of the Alabama State Board of Optometry.

I have served as president of the Huntsville Rotary Club, the YMCA, the Madison County Chamber of Commerce, the United Givers Fund, and as chairman of the board of stewards of the First Methodist Church. In 1959 I served as Alabama crusade chairman for the American Cancer Society.

The American Optometric Association is to optometry what the American Bar Association is to law, or the American Medical Association is to medicine. The membership of our association comes from all of the 50 States and the District of Columbia. The membership is the largest single professional group offering their services in the field of vision care. I am honored to represent this association here today.

Now, as to the purpose of my appearing before this distinguished committee: I hope that I will be able to state this purpose clearly, and I know that I shall state it sincerely. We, the members of the American Optometric Association, once again wish to volunteer the services of our association and its individual members to all agencies of government which are now or may be concerned with the problems of vision care and the rehabilitation of the visually handicapped.

There are many facets in the field of vision care and rehabilitation which are already law. Others are pending and still others will be introduced. I shall return briefly to this subject later.

Mr. Chairman, I am sure that in the fields of rehabilitation and special education, the terms "vision," "blindness," "subnormal vision," "partially blind," "occupational vision," "rehabilitation of the visually handicapped," and many more on this subject will be brought to the attention of this committee.

The American Optometric Association and its membership have pioneered in this field. The records of successful rehabilitation of these visually handicapped are commonplace in individual optometric offices and clinics. Our journals, our seminars, our colleges of optometry, our research facilities make this field of rehabilitation of the visually handicapped our No. 1 project. The results of research, new and improved methods and instrumentation are made available to each member of our profession.

Our profession also supports the American Optometric Foundation, a research organization of which Dr. William C. Ezell of Spartanburg, S.C., has been president for many years. This organization finances research and fellowships in the field of vision not only in optometric schools and colleges, but also in other institutions of higher learning.

We also offer the full cooperation of the American Optometric Association's Department of National Affairs, of which Dr. Joseph M. Babcock of Portsmouth, Ohio, is director, to this committee, and we urge when legislation is proposed pertaining to the visually handicapped and their rehabilitation, that members of our profession be named to serve along with members of other professions in the health field.

Now, very briefly as to pending legislation that may affect our membership: First, we want to thank the House of Representatives for passing H.R. 10, which is now before the Senate. This bill, as you may well remember, will provide the self-employed an opportunity to secure some slight income tax benefit provided they elect to

augment their social security with a voluntary retirement fund. We urge that the Senate act favorably on this bill.

Second, and this is to me the crux of the matter, is bill H.R. 7966. The enactment of this bill will mean a great deal to the visual welfare of our veterans from the Spanish American War through the Korean conflict. We certainly solicit the support of the members of this committee for the passage of H.R. 7966. However, in this presentation I am using it as an example of discrimination against our profession.

For example, under existing conditions, a patient of mine goes to a veterans' hospital or facility. He may receive the services of an optometrist while in the hospital, but when he is dismissed for outpatient care, he may not come back to me or any other optometrist, but must be referred for outpatient care only to another profession in the vision care field.

It does not appeal too much to our ego to have a patient for a number of years, and then have the patient go into a federally supported institution and receive outpatient care afterward from another person. They say to him that it is impossible for him to come back to me.

Certainly this procedure is unfair to the optometrists, but in even a larger degree it is unfair to the veteran.

As stated before, the membership of the American Optometric Association is the largest in the vision care field and offices of its members are to be found in the smaller cities, towns, and rural counties. In many cities, towns, and counties the only professional care represented in the vision care field is optometry.

For instance, this Seventh Congressional District of Alabama includes nine counties, all of which have optometrists for vision care. Only four of these counties have both optometrists and other professional men in the vision care field. In the State of Alabama there are 36 counties in which all of the vision care and rehabilitation is provided for by optometrists. Thirty-six out of the sixty-seven counties in Alabama have no other person in the visual care field except optometrists.

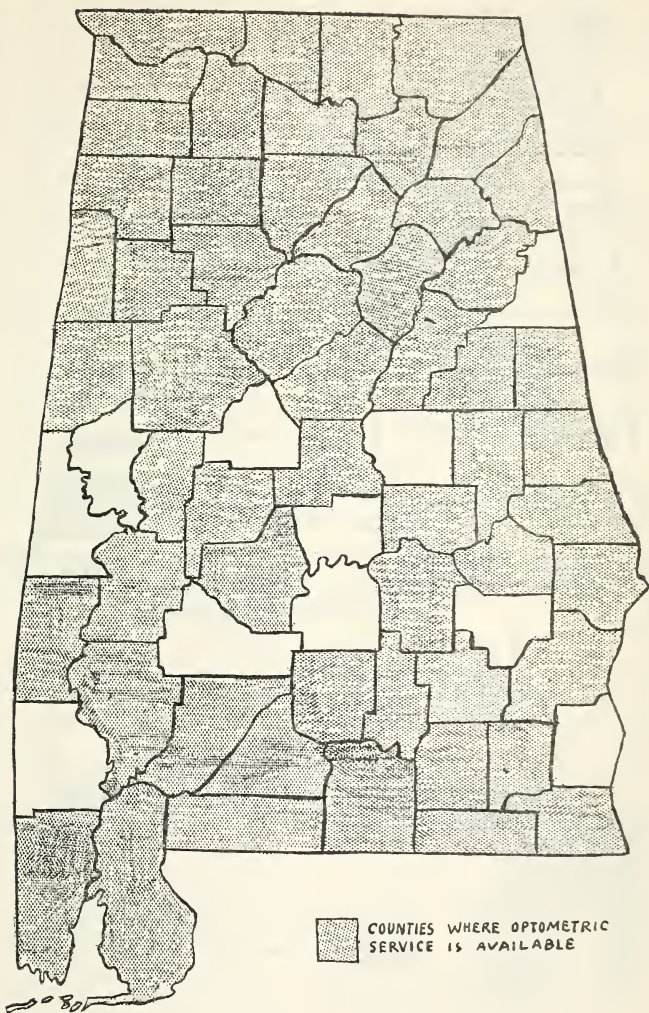
Attached to my statement are two maps. Map No. 1 represents the counties in Alabama which have optometric offices, most of them. There are about six that do not have. The second map, map No. 2, represents the counties in Alabama that have professional people that do eye work that are not optometrists; in other words, ophthalmologists or eye, ear and nose and throat specialists, which shows that the coverage we have is much greater. I think that ratio would exist in the other States in the Union as well.

This information was compiled from the records of the Alabama Optometric Association and the membership roster of the Alabama Medical Association. We believe that Alabama reflects the national picture.

Map No. 2 shows at a glance the many areas in our State that necessitate a great deal of travel to veterans, who perhaps can least afford it. Map No. 1 shows that this condition would be greatly alleviated by the passage of H.R. 7966, and would make available to the veterans throughout the State vision care on an outpatient basis, close to home.

(The maps referred to follows:)

MAP 1



MAP 2



Dr. GIBSON. We submit that optometry should be represented on all boards, committees, and other agencies established by Government dealing with the problems of vision and its rehabilitation, and that the American principle of freedom of choice by the individual should not be redistributed. He should be allowed to receive optometric vision care if he so desires.

Optometry has come of age. A person must take 2 years of pre-optometry and 4 years in a professional school. In Alabama we have a period of internship before he is entitled to practice.

We, therefore, again volunteer the services of the standing committees of the American Optometric Association to this committee, and sincerely trust that any legislation which it may recommend to the Congress will provide that optometry may be fully utilized in the service of all who are visually handicapped, and that State and local authorities, in order to secure matching funds for their vision programs, must make available to the recipients who desire to utilize them the services of optometrists.

Mr. ELLIOTT. Thank you very much for your testimony, Dr. Gibson. We appreciate it very much. It is clear and compelling. It will be very helpful to us in our deliberations.

Our next witness is Miss Mary P. Marriott, director, Rehabilitation Center, Louisville, Ky. Miss Marriott represents the Kentucky Division of the American Cancer Society.

We are happy to have you and you may proceed in any manner you desire, subject to our time limitation, for which I apologize but which is necessary in view of the circumstances.

STATEMENT OF MISS MARY P. MARRIOTT, DIRECTOR, REHABILITATION CENTER, LOUISVILLE, KY., REPRESENTING KENTUCKY DIVISION, AMERICAN CANCER SOCIETY

Miss MARRIOTT. I consider it a privilege to be here. Mr. Tucker, the executive director of the Kentucky Division of the American Cancer Society, could not be here. He is a member of the Rehabilitation Center Board of Directors and supports our postlaryngectomy speech program.

Rehabilitation Center, Inc., of Louisville, opened in 1954 as a non-profit private agency dedicated to the rehabilitation of physically handicapped persons of all age groups during and after the acute phases of their illnesses. Medical direction is supplied through two full-time physicians who are accredited specialists in the fields of physical medicine and rehabilitation. The agency is affiliated with the University of Louisville School of Medicine. Its medical director is head of the university's Department of Physical Medicine and Rehabilitation.

Services consist of medical evaluation and treatment, physical therapy, occupational therapy, social service, psychological and vocational counseling, recreational therapy, rehabilitation nursing, prosthesis and bracing—all designed to return the handicapped child or adult to as near normal living as possible. Special clinics held are the upper and

lower extremity prosthetic clinics and the cardiac work classification clinic.

To achieve its aim, the center must employ professional personnel especially trained to meet the patients' needs. The staff must act as a team, recognizing that each person is entitled to every service offered, but that he must often be helped to understand the need for and want the treatment before he can obtain desired value from efforts in his behalf; in other words, members of the team must realize that their goal must be the patient's goal before any amount of treatment will achieve lasting results.

The philosophy of the rehabilitation center is based on the concept of treating the patient as an individual human being and not as a disease or a deformity. His differences and his requirements are studied, and he is helped to reach his best adjustment of his functional level.

It should be pointed out that rehabilitation starts the moment the physician or surgeon begins applying curative measures. The practicing physician must always think of the end results of medical or surgical treatment. New skills learned in the physical restoration of the patient must be applied from the day the patient becomes acutely ill.

Bed position, for example, must be thought of to prevent contractures and to enhance early activity. Muscles and joints must be kept in as good functional state as possible. Many physical procedures to keep the body in good physiocondition during recovery from an acute illness are in use today in modern treatment of disease. In addition, vocational and social services are utilized during the acute phase or very early convalescent phase when indicated.

As shown in recent surveys, many of the chronically ill patients who are kept in the hospital out of medical necessity ordinarily do not receive the treatment that is necessary for the successive stages of rehabilitation to be productive. This fact, coupled with an increasing incidence of traumatic injury and an aging population points up to the ever increasing need of rehabilitation facilities.

Take postlaryngectomy speech for instance. It has been estimated by the national office of the American Cancer Society that there are between 12,000 and 15,000 laryngectomized individuals, with approximately 1,000 new cases occurring annually in the United States.

Postlaryngectomy speech training offers one of the most complete rehabilitation processes known to physical medicine; yet, until recently, facilities for this specialized field have remained inadequate. Few cities have had organized postlaryngectomy speech training programs, and students in speech have graduated with little or no training in this particular field.

In the past 10 years, however, there has been an increasing interest in rehabilitating the laryngectomized individual and more schools and agencies have initiated programs in an attempt to meet the growing need.

If this need is to be met adequately, more teachers must be trained in the specialized techniques of developing postlaryngectomy voice. The Department of Health, Education, and Welfare, Office of Vocational Rehabilitation, sponsors at least two short courses in university-connected medical schools, but this program needs to be expanded in order to provide enough teachers to train all laryngectomies.

There is a need, too, for public education in order that laryngectomized person may be accepted by society and be able to return to gainful employment.

Consider that there are approximately 8 million people of all ages in the United States who are in need of speech and hearing therapy. To treat this number, 20,000 workers are needed in this field. This includes pathologists who diagnose, teach, and do research; therapists who work in the clinical situation; and correctionists who work with articulation in the school situation.

At the present time there are 2,000 workers in this field who are certified by the American Speech and Hearing Association. Approximately 5,000 are in training. This includes students and teachers who are working in the field for certification. To meet the present need, we should have approximately 1,500 graduates per year in the field of speech and hearing therapy; however, we have only 400. This gives a picture of the great need in this field.

In the field of physical medicine and rehabilitation there are from 300 to 400 trained physicians. The patient need approximately doubles this number. This situation applies to physical therapists, occupational therapists, vocational counselors, social workers and psychologists.

The population increases each year. With more and more children, the need will be greater each year.

The United States is a great place for organizations to help people. We have societies which are interested in all the diseases of the body. You can start up at the head and find that emotionally disturbed children have the Society for Mental Hygiene to help them; we have blind children, and the Society for the Prevention of Blindness, and a Society for Prevention of Deafness. We have societies to help those with cardiac conditions, poliomyelitis, arthritis, cerebral palsy, cancer, muscular dystrophy, multiple sclerosis.

A society is started around every disease. All of these efforts deserve praise and help but one wonders about the person who has a disease which does not have an organization to help him.

We must remember that in rehabilitation we do not treat diseases but persons with disabilities. It is just as important to know what person has the disease as what disease the patient has. It is easy to become so interested in the cause and diagnosis that we forget we are treating persons with disabilities.

Appeals for aid on an emotional basis is justifiable, but we should present the economic aspect of the problem. If a child, or adult, is so handicapped by a residual disability that it is necessary to place him in an institution, it will cost a minimum of \$2,000 a year for his care. If you put 10 children in an institution you are spending \$20,000 a year. Why not spend a few thousand right now and keep them out of an institution, and make their lives happier and more productive?

Urgent needs in rehabilitation as we see them at the Louisville center are:

(1) Training for postlaryngectomy speech therapists. Our speech therapist has had a complete laryngectomy. She has had therapists work with her and is now able to pass this training on to our patients

in such a way that they benefit greatly. Surgeons refer patients when they enter the hospital for surgery so that the therapist can help them to understand just what is coming—that when they recover from the anesthetic after surgery, that is, when they wake up in their hospital rooms, they will not be able to speak again until they are trained. So many people have had these laryngectomies that trained speech therapists are greatly needed.

(2) Schools of physical and occupational therapy, as well as schools of speech therapy in Kentucky would help to train local people and result in less turnover of personnel. These occupations also should be publicized to a greater extent so that more young people will be drawn to them.

(3) Scholarships: Aids to students in training for speech, occupational and physical therapy might help to interest young people as workers in these fields.

(4) Architectural planning to meet the needs of the handicapped youth in each new school, including special facilities such as elevators, ramps, and restrooms allowing the student to get his wheelchair into the room. This is needed so that the handicapped youth need not be regulated to special classes, but may attend school in normal school situations at regular schools.

(5) Government grants to enable universities to establish the necessary curricula to train students in physical, occupational, speech therapy, et cetera. I would like to see the Government give out-and-out grants to universities to furnish personnel, as too often the universities do not have money for matching grants for such purposes.

(6) Larger appropriations for the State bureau of rehabilitation services. This agency does not have enough money to cover the needs of people that need their services. An out-and-out Government grant would give the agency the money to meet the needs and expand their program.

If we are to help handicapped persons become physically, emotionally, socially, educationally and vocationally prepared to take their places in the community, we must all work together as a team to obtain our objectives.

Mr. ELLIOTT. Thank you very much, Miss Marriott. Your testimony has been very fine and it will be helpful to the committee.

I wish to recognize Judge Marvin Scott, a longtime judge of Cullman. We are happy to have him with us today.

Also, may I note the presence here of a former Member of Congress from the State of Tennessee, Mr. Pat Sutton, who now, I believe, has become a resident of Alabama.

Mr. SUTTON. That is right, Mr. Chairman.

Mr. ELLIOTT. We are happy to have you.

Our next witness is Mr. Milton K. Cummings. Is Mr. Cummings here?

If Mr. Cummings is not here, our next witness is Mr. Harry DeLany, executive director of the Georgia Association of Workers for the Blind.

Mr. DeLany, the Subcommittee on Special Education is happy to have you as a witness. You may proceed at this time.

STATEMENT OF HARRY DeLANY, EXECUTIVE DIRECTOR, GEORGIA
ASSOCIATION OF WORKERS FOR THE BLIND, ATLANTA, GA.

MR. DeLANY. Mr. Chairman, members of the committee, I would address myself, I think, primarily to the recommendation that you pass H.R. 3465.

It seems to me that this will provide a great deal of legislation that has been needed at least in our Southland for a good many years.

I can identify myself with the rehabilitation movement since 1923, Mr. Chairman, when I was the first youngster sent to college, that is liberal arts college, on rehabilitation. There we get into objective, Mr. Chairman. I have been having trouble with that word "objective" for all these years, both as a client in rehabilitation and as a counselor in rehabilitation, for I did serve with the State department of education in my State as a counselor in vocational rehabilitation.

When you send your own child to college, do you demand of that child that he tell you precisely what he is going to do when he finishes college?

I will answer for you that you do not, because he does not know, and neither does the blind child. Yet we require of our handicapped people that they tell us what they are going to do at the time they start college, not when they finish. That has always been a bugaboo to me.

The matter of independent living is the next item. It seems to me that if we can get a bill through where we do not have to prescribe the objective, it will give for a better independent living. We would greatly facilitate the whole field of rehabilitation.

Now, as to workshops in rehabilitation, Mr. Chairman, I would address myself there to that subject for a moment and say to you this: that during the period from 1923 to 1943, we had very few departments for the blind as separate entities in rehabilitation, and there were very few blind people rehabilitated by the several States. Only those people who had, maybe, a special ability, or who demonstrated by some—since I said I went to college on rehabilitation, I hate to say they had to be fairly smart, but they did—they had to have some sort of special ability or they were left in the cold.

If we put our workshops for the blind and just make workshops for the rehabilitation of the handicapped out of them, it will mean that our blind people will be, generally speaking, left out, unless the blind person shows a special adaptability.

As for evaluating services, I would like to say a word or two on that.

On evaluating the services of rehabilitation, I do think that there are several unmet needs there. First, we should go back and review the cases that we have handled in the past 20-odd years, and see how many of those cases could be restudied, and maybe the objective changed, and the person rehabilitated so that it would enhance his livelihood and his standard of living, and his own ability to be a normal citizen in his community.

We have rehabilitated a good many people by buying them a couple dozen chickens when, if we are going to put them on a poultry farm, let's make them either study poultry husbandry and really get into

the business, or just leave off the couple of dozen chickens because that does not work. I admit that it has helped, and in family rehabilitation, where we help the members of the family, that is a great field, Mr. Chairman.

I do not mean to minimize that. But it has been overdone in our State. We have some 10,400 blind people in our State, and we have a great many people that will not come under the definition of blindness. They are between 20-70 and 20-200; they have vision between 20-70 and 20-200. These people are the forgotten people, and it seems to me that in putting out this new 3465 we should put a good deal of thought to those people. But I believe that those people would be better handled by your agencies for the blind than by general rehabilitation as they are handled in most States now.

The people in general rehabilitation are not specifically trained to work with visually handicapped people. After all, I believe it is the general consensus that of all rehabilitation clients, the visually handicapped client is the most difficult client to train and place.

That concludes my statement, Mr. Chairman.

Mr. ELLIOTT. Are there any questions of Mr. DeLany. If not, we thank you, Mr. DeLany, very much for your kindness and presentation.

Mr. DELANY. Thank you for allowing me to come.

Mr. ELLIOTT. Your testimony has been very helpful.

Our next witness is Mrs. J. A. Holecamp, of the Alabama Congress of Parents and Teachers, Birmingham, Ala.

STATEMENT OF MRS. J. A. HOLECAMP, ALABAMA CONGRESS OF PARENTS AND TEACHERS, BIRMINGHAM, ALA.

Mrs. HOLECAMP. Mr. Chairman and members of the Subcommittee on Special Education of the Committee on Education and Labor of the U.S. House of Representatives, I am here representing Mrs. G. C. O'Kelley, president of the Alabama Congress, a branch of the National Congress of Parents and Teachers.

The Alabama Congress of Parents and Teachers, speaking through its president and her designated representatives, expresses sincere appreciation for your invitation to appear at this public hearing and speak on behalf of one specific need of Alabama's children.

We are not here to speak for any particular bill, although we are deeply interested in securing provisions whereby we may have more trained personnel who know, understand, and are prepared to help with the education of exceptional children.

We, as an organization of more than 200,000 memberships, are cognizant of this great need to provide classes for these children who come within the framework of special education. Let us keep before us, however, that we are interested in all children, the average, the gifted, the exception, America's richest and most valuable resource.

We believe in public education. We believe that the public school system should be maintained and strengthened. We believe emphatically that education is a State function, to be administered through local school boards. Annually, at our State convention, where delegates assemble from our 866 local parent-teacher associations, we adopt a program of legislation. We support this program from the

local level to the State legislature. Therefore, our membership, through its convention action, approves this program each year.

Our invitation to this hearing was communicated to the members of the board of managers, which was in session when Mrs. O'Kelley received it. I am here today through its authorization.

The Alabama Congress of Parents and Teachers is vitally interested in helping with the special education program. This year it sponsored two regional meetings on the curriculum, with special education included. The State supervisor of special education was on the program. Local parent-teacher associations have centered program emphasis and given assistance to the special education teachers.

Councils have worked closely and effectively with superintendents in getting classes underway by providing moral and financial support for special equipment. The trend is forward to help provide education for these exceptional children through special classes which are an integral part of the public school program.

It would be impossible for a voluntary and strictly nonprofessional person to know all the technical facts concerning exceptional children in this State.

I am the mother of four physically and mentally strong children; I can, therefore, speak proudly of them, want the best education for them, and at the same time keep the desire for those less fortunate in mind.

In 1955 our State legislature enacted into law a bill relating to the education of exceptional children. This law provided for the State board of education to provide funds to city and county boards of education. The rules and regulations are well known. This bill became a law in August of that same year.

Alabama has a State supervisor in special education. She is well qualified and well trained. There is an urgent need for more staff on the State level.

Alabama has 305 teachers employed in 77 school systems. Alabama has 4,600 children enrolled in these classes. It is estimated that 80,000 children need to be in special classes; yes, 80,000 children.

Alabama is seeking to help the exceptional children, but the problem is great. It needs further aid for these children in order to provide special education classes.

Our educational needs in Alabama are many. Each has an urgency. In the area of special education, the need is long.

You, gentlemen, are familiar with these facts. I need not present them to you; my confidence and respect for your knowledge relative to your committee's task is implicit.

The Federal Government can help by providing funds for use through State departments of education in this area as it is already doing in many other areas. The hour is here; let us not be late.

Mr. ELLIOTT. Thank you very much, Mrs. Holecamp.

Are there questions of Mrs. Holecamp?

Mr. QUIN. I just want to see if I have the figures straight.

You say there are 4,000 students presently enrolled in special classes and there is a need for special classes for 80,000?

Mrs. HOLECAMP. Yes, sir.

Mr. QUIN. And how many do you have in residential institutions, like the school for the deaf, the school for the blind, and so forth?

Mrs. HOLECAMP. I do not know. I am sure that Mr. McBride, when he testifies, will be able to give you those figures.

Mr. QUIE. Under that 1955 law, how can students in a rural community, where it would not be possible, perhaps, to have a special class, receive special education?

Mrs. HOLECAMP. I could not answer that, either. Maybe someone that testifies later this afternoon or tomorrow can answer that.

Mr. ELLIOTT. Thank you very much, Mrs. Holecamp.

Are you on the legislative committee, Mrs. Holecamp?

Mrs. HOLECAMP. I am the chairman of the legislative committee for the State of Alabama Congress of Parents and Teachers.

Mr. ELLIOTT. It seems as though you have been making a lot of good progress this year.

Mrs. HOLECAMP. Thank you. You have, too.

Mr. ELLIOTT. Thank you, ma'am.

Our next witness is Mr. J. M. Warren, president of the Tennessee Federation of the Blind, Inc., of Nashville, Tenn.

STATEMENT OF J. M. WARREN, PRESIDENT, TENNESSEE FEDERATION OF THE BLIND, INC., NASHVILLE, TENN.

Mr. WARREN. Mr. Chairman and members of the subcommittee, for the record, my name is J. Marshall Warren. I reside at 100 South 16th Street, Nashville, Tenn. I am president of the Tennessee Federation of the Blind, an organization of blind men and women throughout the State.

I am also chairman of the advisory committee, the committee that meets periodically with the department of welfare, the Tennessee Department of Public Welfare, to discuss problems that concern the program for the blind as that department administers it. This committee serves as close liaison between the blind and the officials of the department that administers the program for the well-being of the blind.

Although I have been totally blind since the age of 2, it has been possible for me to live a full, active life. For 15 years I conducted a country store and for the past 20 years I have been engaged in the mercantile business. For the past 20 years I have participated in real estate, buying and selling real estate, handling mortgages, repairing and building homes.

In conjunction with other activities, I share a major responsibility for the management and operation of a 600-acre dairy farm. Aside from my role in organizations of the blind and business activities, it has been my privilege to serve in the Tennessee Legislature.

I wish to commend this committee, Mr. Chairman, for its inquiry into programs for the blind, and its desire to improve those programs.

In my capacity as president of the Tennessee Federation of the Blind, for the time I have participated in the workshop in Atlanta, and for the time available to me, I wish to discuss the so-called independent-living bill.

The objectives sought in the enactment of this so-called independent-living bill are worthwhile. However, if the legislation of the type proposed, especially legislation of the type now pending before this committee, H.R. 3465, should be enacted without proper

safeguards, and disadvantages of such legislation probably would outweigh any gains which might be realized from it.

For more than a year the controversy concerning the independent-living bill has raged throughout the country. Blind persons have more to gain or lose by the enactment of this legislation than perhaps any other group. Independent legislation as a part of the Vocational Rehabilitation Act would not only affect the unemployable blind person, it would affect almost every vocational rehabilitation client in one way or another.

Many services to the blind are now considered as being within the scope of this vocational rehabilitation. It would provide many of those services not now provided. This means that home teachers, for example, who are paid entirely from State funds, except in those rare instances where the home teacher works with a vocational rehabilitation client, the time spent in such work can be charged against vocational rehabilitation case service funds, but the redtape and the recordkeeping involved are so cumbersome that many States do not take the trouble to claim Federal reimbursement. The result is that salaries and standards in the field of home teaching are far below those in rehabilitation.

It is not difficult to see why this is so. If a State gets two Federal dollars for every State dollar that it puts into the salary of a vocational rehabilitation counselor, it can pay that counselor \$5,150 for a total investment of only \$1,700 of State money. Thus it will cost the State more to hire a lone teacher at \$3,000 than to hire a rehabilitation counselor at \$6,000.

If the independent living bill were enacted, home teachers' salaries would undoubtedly come within the scope of the legislation. Both salaries and standards would improve, and a broader program of services would be made available to the blind. This would be a clear gain and much to be desired.

On the other hand, the independent-living bill as it now stands would further complicate and confuse vocational rehabilitation services for the blind. It would likely mean that fewer blind persons would be placed in competitive employment.

The independent living bill is a logical outgrowth to the 1954 amendments to the Vocational Rehabilitation Act. Before 1954, the emphasis in rehabilitation was on vocational training and job placement. The Federal regulations were so drawn that considerable incentive was given to the States to place disabled persons in competitive employment.

The 1959 amendments passed placed the emphasis on physical restoration and what has been called medical rehabilitation. The Federal regulations were changed to reflect this new emphasis. The term "remunerative occupation" was defined to mean employment in the competitive labor market, practice of a profession, self-employment, homemaking, farm or family work, including work for which payment was in kind rather than in cash, sheltered employment and home industries or other homework of a remunerative nature.

A State could, and still can, claim a vocational rehabilitation closure on a person making 10 cents an hour, making no salary at all, drawing no public assistance when the State public assistance took

its case, making potholders, or returning home to sit in an armchair following a cataract operation, a family worker.

Since rehabilitation of this type is counted remunerative employment, as rehabilitation involving the more difficult task of placing disabled persons in competitive employment, the incentive is to make these easier placements.

If the independent living bill should be enacted, without substantial changes, it would continue the trend which was begun in 1954. Agencies for the blind would probably further deemphasize their job hunting and placement activities, and would spend even more time testing, giving physical restoration services, counseling diagnostic work, and to specially helping the blind client to achieve independent living, but not a job.

The 1954 amendments to the Vocational Rehabilitation Act, as well as the proposed independent living amendments, point up the differences between vocational rehabilitation of the blind and vocational rehabilitation of other disabled persons.

The blind, of course, comprise only a small fraction of the total number of disabled people in the Nation. Therefore, administrative planning and program emphasis at the Federal level in those States having no special vocational rehabilitation agency for the blind, are usually in terms of social group, not in terms of the special needs of the blind.

Mr. ELLIOTT. Mr. Warren, let me interrupt you there.

We have used our customary 10 minutes, but I will give you 2 or 3 minutes additional to finish whatever you may care to say orally. Then I will make it possible for your entire statement to be placed into the record following your oral statement.

Will it be possible for you to furnish us a copy of your statement in full at some future date?

Mr. WARREN. We will do that, Mr. Chairman, yes.

Mr. ELLIOTT. You take 2 or 3 minutes to finish what you desire to say.

Mr. WARREN. I would like to say this, Mr. Chairman: There are a lot of benefits provided in this independent living bill. The point that we want to make is that we want those benefits for the blind, but we do not want to give up the one important thing to a blind person, and that is training and placement in competitive employment, where he can earn his living.

My conception of an independent living is a living that he earns himself and not something that is handed out to him. These benefits that this bill would provide should not be administered by the same agency. If they are administered by the same agency they should not be administered by the same personnel.

We want the emphasis in vocational rehabilitation for the blind placed on training the individual and helping him get to a place to earn his living. Provide all these other benefits, but place them not under the Division of Rehabilitation. Probably they are more nearly social and health benefits than they are vocational rehabilitation services.

I think with the filing of this statement, you will get an idea of what we have in mind.

Mr. ELLIOTT. Thank you very much, Mr. Warren.

Are there questions of Mr. Warren?

Mrs. GREEN. I have one question of Mr. Warren.

The point that you raised in the objection to putting the care of the help to the blind under vocational rehabilitation, this question has been raised in my own State. Is this a national trend? Is there an effort being made to do this in every area?

Mr. WARREN. Well, it seems if you want a perfectly frank answer, that will make it a good deal easier on vocational people, because their closures can be made before they have secured a job for a client.

It seems that this bill, I guess, has the support of the rehabilitation folks of the Nation.

Mrs. GREEN. There is a very good reason in my own State and I wondered if this is true in other areas, that vocational rehabilitation has offices in very many areas of Oregon. We have 36 counties and it is a rather good size State geographically. Therefore, they can give better service to the individual. There are not so many offices for the blind. It becomes necessary for them to transport an individual maybe 300 miles. But if it was under vocational rehabilitation, it might be necessary to transport that individual 10 miles.

Mr. WARREN. We maintain that vocational rehabilitation for the blind should always be administered by a separate agency or division, or separate personnel, rather than administered by the agency or division that administers general rehabilitation, rehabilitation for other handicapped persons.

It is more difficult to rehabilitate blind people than it is a lot of other disabled persons, and the blind are neglected because they take the pattern of least resistance, and their attention is centered more on the easier client to rehabilitate.

Mrs. GREEN. But if we insist on this, will the blind actually be more inclined or will there be a greater possibility of his being neglected because the services are not available in his area?

Mr. WARREN. In our State, in Tennessee, and I believe in 30-some-odd States—I am not sure about that figure, however—the vocational services for the blind are separate from the general rehabilitation services, services for all other handicapped groups. We have them separate.

The vocational services in Tennessee are part of the division of services for the blind, and the other vocational services for the other groups is in the department of education.

Does that sort of answer your question?

Mrs. GREEN. Yes.

I still am not sure. They are separate in Oregon, of course, too, but I am not sure but what more services would be available if they were combined just because of the offices and the number of people involved.

Mr. WARREN. That has been tried out.

In the beginning they were together, and they found that it did not work well to rehabilitate the blind, having them together. For that reason they were separated.

Mrs. GREEN. Thank you.

Mr. ELLIOTT. Thank you, Mr. Warren.

(Mr. Warren's statement follows:)

STATEMENT OF J. MARSHALL WARREN, PRESIDENT, TENNESSEE FEDERATION OF THE BLIND, INC., NASHVILLE, TENN.

Mr. Chairman and members of the Subcommittee on Special Education, my name is J. Marshall Warren and I reside at 100 South 16th Street, Nashville, Tenn. I am the president of the Tennessee Federation of the Blind, a statewide organization of blind men and women. I am also the chairman of the Advisory Committee of the Blind. This committee meets periodically to consult and advise with officials of the State department of public welfare. It provides a close liaison between the blind and those who administer programs for their aid and rehabilitation.

Although I have been totally blind since the age of 2, it has not precluded my living a full, active life. I operated a country store for 15 years and since 1920, I have been engaged continuously in the mercantile business. For the past 20 years I have been fortunate enough to succeed in the real estate business, including buying and selling property as well as handling mortgages and residential construction and repair. In conjunction with other activities I share major responsibility for management and operation of a 600-acre dairy farm. Aside from my role in organizations of the blind and business activities, it has been my privilege to serve in Tennessee's Legislature.

Mr. Chairman, I wish to commend this subcommittee for its searching inquiry into the programs for the blind and its desire to improve these programs. I wish to commend the subcommittee particularly for the leadership which it is providing in terms of consultation with representatives of organizations of the blind in the conduct of its special study. In my capacity as president of the Tennessee Federation of the Blind I participated in the Atlanta workshop sessions on the visually impaired and I appreciated the opportunity to do so.

In the brief period of time available to me, however, I wish to discuss the "independent living rehabilitation" bill now pending before the subcommittee.

INDEPENDENT LIVING REHABILITATION

The objective which is sought by the enactment of independent living legislation is extremely worthwhile; however, if legislation of the type proposed—especially legislation of the type now pending before this committee (H.R. 3465) should be enacted without proper safeguards, the disadvantages of such legislation would probably outweigh any gains which might be realized from it. For more than a year the controversy concerning the independent living bill has raged throughout the country. Blind persons have more to gain or lose by the enactment of this legislation than perhaps almost any other group. Independent living legislation as a part of the Vocational Rehabilitation Act would not only affect the unemployable blind person, it would affect almost every vocational rehabilitation client in one way or another. Many services to the blind are not now considered as coming within the scope of vocational rehabilitation. This means that home teachers, for example, must be paid entirely from State funds, except in those instances where the home teacher works with the vocational rehabilitation client. The time spent in such work can be charged against vocational rehabilitation case service funds, but the redtape and recordkeeping involved are so cumbersome that many States do not take the trouble to claim the Federal reimbursement. The result is that salaries and standards in the field of home teaching are far below those in rehabilitation. It is not difficult to see why this is so. If a State gets \$2 Federal for every State dollar that it puts into the salary of a vocational rehabilitation counselor, it can pay that counselor \$5,100 for a total investment of \$1,700 of State money. Thus, it will cost the State more to hire a home teacher at \$3,000 than a vocational rehabilitation counselor at \$6,000. If the independent living bill were enacted, home teaching salaries would undoubtedly come within the scope of the legislation. Both salaries and standards would improve, and a broader program of services would be made available to the blind. This would be a clear gain and much to be desired.

On the other hand, the independent living bill as it now stands would further complicate and confuse vocational rehabilitation services for the blind. It would likely mean that fewer blind persons would be placed in competitive employment.

The independent living bill is a logical outgrowth of the 1954 amendments to the Vocational Rehabilitation Act. Before 1954 the emphasis in rehabilitation was on vocational training and job placement. The Federal regulations were so drawn that considerable incentive was given to the States to place disabled persons in competitive employment. The 1954 amendments as passed placed the emphasis on physical restoration and what has been called medical rehabilitation. The Federal regulations were changed to reflect this new emphasis. The term "remunerative occupation" was defined to mean (subpt. A, 401.1p) "employment in the competitive labor market; practice of a profession; self-employment; homemaking, farm or family work (including work for which payment is in kind rather than in cash); sheltered employment; and home industries or other homebound work of a remunerative nature." A State could, and still can, claim a vocational rehabilitation closure on a person making 10 cents an hour, making no salary at all, drawing more public assistance than when the State rehabilitation agency took his case, making potholders, or returning home to sit in an armchair (a family worker) after having been operated on for a cataract. Since rehabilitations of this type are counter as closed, remuneratively employed, as are rehabilitations involving the more difficult task of placing disabled persons in competitive employment, the incentive is to make these easier placements.

If the independent living bill should be enacted without substantial changes, it would continue the trend which was begun in 1954. Agencies for the blind would probably further deemphasize their job hunting and placement activities and would spend even more time testing, giving physical restoration services, counseling, doing diagnostic work, and (most especially) helping the blind client to achieve independent living—but not a job.

The 1954 amendments to the Vocational Rehabilitation Act and the proposed independent living amendments point up the difference between vocational rehabilitation of the blind and vocational rehabilitation of other disabled persons. The blind, of course, comprise only a small fraction of the total number of disabled people in the Nation. Therefore, administrative planning and program emphasis at the Federal level and in those States having no special vocational rehabilitation agency for the blind are usually in terms of the total group, not in terms of the special needs of the blind.

The rehabilitation of the average disabled person usually involves medical work or some type of physical therapy—learning to use prosthetic devices, learning to walk or use muscles after polio, developing motor coordination, learning to live with one's limitations after a heart attack, correcting a speech defect, or learning to use a hearing aid or brace. In short, rehabilitation for the average disabled person who is not blind usually means physical restoration in one form or another, or some related process. When rehabilitation is viewed in this light, the 1954 amendments and the present independent living legislation are logical next steps. Increasing stress is placed upon diagnosis, medical services, therapy and physical restoration. Vocational rehabilitation services and hospital services are beginning to be regarded as related parts of one overall process. The disabled person is more and more thought of as a patient.

Rehabilitation of the blind, on the other hand, is something else again. The average blind person in need of rehabilitation does not have a health problem. He is not sick. He does not need physical restoration. Lenses will not help him. He cannot be taught new techniques for using his eyes. His needs are entirely different from those of the patient. He must have help in adjusting to his blindness. He must come to an understanding of the fact that it need not keep him from doing the things he has always done. He must have training in skills and techniques—-independent travel, braille and typing, etc.; above all, he must have help in finding a job. The average blind man, just as the average sighted man, is not a good salesman. He needs a vocational rehabilitation placement man to help him convince an employer that he can do a job. Considered in these terms, the 1954 amendments did not advance rehabilitation of the blind. Nor, as now drawn, would the independent living bill do so. Medical help and physical restoration are vitally important services. They are necessary for the blind as well as other groups. The question is not their importance, but by whom they should be administered, what emphasis they should receive, and what their relationship is to vocational rehabilitation.

In view of the foregoing comments the following specific proposals are made:

(1) Public Law 565 should be amended so as to provide for Federal matching funds as grants in aid to the States for home teaching programs for the blind,

regardless of what department of State government administers such program. The Federal share of the cost of the home teaching program should be the same as the Federal share for the State under section 2 of Public Law 565.

(2) If the independent living bill (H.R. 3465) or any similar legislation is enacted, any agency of State government should be permitted to administer the independent living program. If the independent living program for the blind is administered by a State agency which also administers to program of vocational rehabilitation for the blind, the personnel (other than administrative) engaged in the day-to-day operation of one program should not be permitted to spend any time working in the other program.

(3) Public Law 565 should be amended to require changes in the reporting systems of the State agencies doing rehabilitation of the blind, and in the reporting system of the Federal Office of Vocational Rehabilitation a more realistic definition of "remunerative employment" should be established, and a clear differentiation should be made between types of rehabilitation closures.

(4) The services contemplated under the independent living legislation are greatly needed to promote the general welfare of the blind, but they should be regarded more as health, welfare, and medical services than as rehabilitation, and they should be so planned and administered as not to weaken or water down the program of helping the blind to achieve regular, competitive employment.

I thank you.

Mr. ELLIOTT. Our next witness is Mrs. Christie W. Summers, of Jasper, Ala.

Mrs. Summers is the director of our school in Jasper, Ala., that offers special educational facilities and training to the mentally retarded, and perhaps other groups of disabled children.

Will you give your exact title, Mrs. Summers?

STATEMENT OF MRS. CHRISTIE W. SUMMERS, JASPER, ALA.

Mrs. SUMMERS. I would like to say to the Honorable Carl Elliott and members of the committee that I feel it is a privilege to be with you today. I want to commend you on what you have done and what you are doing for us, in the interest of education.

Mr. ELLIOTT. We are happy to have you. It is a pleasure for all of us, too, to work in the field of education with one as competent and determined as you are.

Mrs. SUMMERS. I am going to be very brief and tell you what I think are the emergencies. I am speaking as an individual now, please.

Some of our most urgent needs in the southern region in the field of special education and rehabilitation are as follows: More and better trained personnel, evaluation centers, and research. I did not put them in order. I merely am making a statement.

Every child is entitled to an opportunity for education and employment appropriate to his physical and mental abilities or possibilities by just being born an American.

Mr. ELLIOTT. That is his birthright, isn't it?

Mrs. SUMMERS. That is his birthright. The cerebral-palsied child is no exception. Cerebral palsy is a southern problem, but not peculiar to the South. It is a national problem, too.

Dr. Winthrop Fields has stated in his latest book that there is a national incidence of 7 per 100,000 in our general population. Walker County has per capita far more handicapped people than any other county in Alabama; 555 handicapped children are in Walker County, under 16, with a general population of 63,769. I

have no definite figures to submit to you, but from the figures I do have, I can truthfully say we have a greater incidence of cerebral palsy in Walker County than the national incidence.

The cost of education, treatment, and training in occupational skills for a cerebral-palsied child is prohibitive for most families and communities who have cerebral palsy in their midst. It is true that adequate research is lacking, too, for the same reason.

Of course, our per capita income in the South is the lowest in the Nation, I believe. Cerebral palsy is a group with which I am most concerned, but what I am going to say will apply to other handicaps as well. It is better to prevent welfare cases than to pay the price welfare will cost taxpayers.

According to rehabilitation statistics, \$1 invested in rehabilitation services will bring back \$10. The profit may be less with cerebral palsy, but there will be a profit, nevertheless, if adequate services are provided for them at an early age.

A weakness in most cerebral palsy programs is the failure to evaluate all of a child's abilities that may be built upon to train him for eventual employment and economic security. This is true in the South, but is not peculiar to us, either. The weakness may be due to ignorance on the part of the parents of the service he provided, but most assuredly it is due to the inadequate number of trained workers and so few training or treatment facilities.

Our program has grown by leaps and bounds in 10 years and is much worthy of being called a program for exceptional children, since Mrs. Alpha Brown has become consultant for special education 3 years ago.

The program now needs to be strengthened by including physical, occupational, speech therapists, as well as psychologists and specially trained teachers on the State staff, for the extent to which a cerebral palsied child succeeds in life's situations depends a great deal upon the facilities which are available for understanding and guiding him during his early years of life. Furthermore, his interests and his attitudes toward his community are directly dependent upon such a program as is provided.

More field clinics for diagnostic and treatment purposes adequately staffed by well-trained persons are required and needed badly in the South. They may be of a mobile nature, but must work closely with the community, the school, and the home for early diagnostic treatment and vocational training.

I hold that vocational training begins right in infancy so that the cerebral palsied child will be ready for further evaluation or training in a center or for on-the-job training program. There is no suitable evaluation center in our area at present. In Birmingham one is being attempted. Miss Stewart, who is well qualified as an occupational therapist, feels she is meeting with success.

She told a group of workers of the physically handicapped last Thursday that such centers were a crucial need in order that rehabilitation could place cerebral palsies in jobs, for CP's, more than any other handicapped persons, are difficult to place because of the complication of their handicaps and the lack of acceptance on the part of the public.

It may not be feasible to establish a strictly CP sheltered workshop. If not, a generic sheltered workshop might be the answer. Until adequate, objective data can be obtained, the type of sheltered workshop established must necessarily be left to the judgment of those experienced in that field.

In Jasper, with our older cerebral palsied children, some 6 years ago we had to use any means available to place them in jobs, so on-the-job training was required. We worked closely with the State rehabilitation services and met with success. It is my opinion that the conversion of the present human waste materials, and that is what the public's view of cerebral palsy is, to have rehabilitated, self-employed, taxpaying citizens, can be accomplished only if money is available to train the needed team of workers and to help establish facilities and long-needed research for this purpose.

This education cannot be financed on a crumbs-from-the-table basis, either. It is not money to be termed charity, because charity is a luxury which the American Government today cannot afford, but a money investment in all exceptional services, so that the Nation itself will not suffer an economic loss.

Thank you.

Mr. ELLIOTT. Mrs. Summers, on behalf of the committee, I want to thank you for that fine statement, and thank you also for the fine work that you do every day as you labor in this endeavor. I am happy that you are getting a new school building for your work. When will it be ready?

Mrs. SUMMERS. We would move in this week, but I have to be out of town on Friday so we will move in the first of next week.

Mr. ELLIOTT. That is wonderful. Thank you very much.

I note that we have in our audience today Mrs. Bob Sherer, Sr., and Mrs. Bernice Youngblood, both from my home town of Jasper, Ala. Mrs. Youngblood also reflects honor on our district as chairman of the State Library Board of Alabama.

We are happy to have you Mrs. Sherer, and Mrs. Youngblood.

Now may I call again Mr. Milton K. Cummings. Has Mr. Cummings arrived yet?

If not, this brings us to our luncheon point. We will reconvene at 1:30 this afternoon. We will begin with the first witness being Mr. Cummings, if he arrives. If not, our first witness this afternoon will be Mr. Percy M. Sessions.

(Whereupon, at 12:35 p.m., the subcommittee recessed, to reconvene at 1:30 p.m. the same day.)

AFTER RECESS

(The subcommittee reconvened at 1:30 p.m., Hon. Carl Elliott, chairman of the subcommittee, presiding.)

Mr. ELLIOTT. The subcommittee will be in order.

The first witness this afternoon is Mr. Percy M. Sessions, chief psychiatric social worker, Alcoholism Clinic, Birmingham, Ala.

While Mr. Sessions is coming forward, let me say that our subcommittee is very appreciative today and will be so tomorrow for the fine service that Floyd Lawson, district supervisor of the Decatur Office of Vocational Rehabilitation, is rendering and has rendered to the success of our hearings.

Mr. Lawson is accompanied here today by Leslie J. Waller, supervisor of the Physical Restoration Services, Division of Crippled Children and Rehabilitation, State of Alabama. Les Waller is a graduate of the Cullman High School and is at home today.

Mr. Lawson is also accompanied by Mr. George L. Hurt, area supervisor of the office of rehabilitation; accompanied by Mr. Holmes A. Turner, area supervisor of the rehabilitation service, Decatur office, and by Mr. Craig Mills, of the rehabilitation service in Florida.

May I say to you gentlemen that the committee appreciates your deep interest and the fine service you render in helping make these hearings possible.

Mr. Sessions, we are happy to have you and look forward to your testimony. I regret that we must impose a 10-minute limitation on the testimony of each witness. With that in mind, you may proceed.

STATEMENT OF PERCY M. SESSIONS, CHIEF PSYCHIATRIC SOCIAL WORKER, ALCOHOLISM CLINIC, BIRMINGHAM, ALA.

Mr. SESSIONS. Mr. Chairman, and members of the committee, this testimony is presented on behalf of a vast number of handicapped people in the South and throughout the Nation—handicapped people who have been championed much less frequently than they have been morally judged and condemned. These are handicapped people for whom special education and rehabilitation are the treatments of choice both for humanitarian considerations and for the practical benefits reasonably expected to accrue therefrom.

These people are handicapped for the reason that they suffer from an overwhelming compulsion to drink alcoholic beverages. They are alcoholics.

Practically, the alcoholic may be defined as any person who ultimately derives less pleasure and satisfaction than misery and suffering from his consumption of alcoholic beverages but who, nevertheless, has a compulsion to imbibe.

Mr. ELLIOTT. Where does that compulsion originate, Mr. Sessions? What is the basis of it?

Mr. SESSIONS. The experiences of the individual, and during the formational years of his childhood. That is the ultimate origin. But there are ever-accruing causes for the illness on up to the time of its appearance. Then there are causes for its aggravation thereafter.

Mr. ELLIOTT. You regard it as an illness?

Mr. SESSIONS. Definitely. Obviously, such a compulsion must rest upon a desire for punishment of the self. Such a desire for self-punishment, in turn, must grow out of feelings of guilt and self-disparagement.

Clinical experience has established the fact that these feelings of guilt and self-disparagement are not often supported with logic or reality but are essentially pathological in nature and are derived usually from misguided, overcontrolling, hostile, rejecting, condemning, and disparaging social attitudes to which the alcoholic has been subjected. Usually it was during the formational years of his childhood that he first experienced these feelings directed toward him, and when the symptoms of alcoholism appear as a result of the individual's accepting as his own these appraisals of himself, the social attitudes

toward him which made him ill in the first place are now magnified, and they confirm him in his course of suicide on the installment plan. For the alcoholic, drinking amounts to this. He says to himself in effect, "I am a miserable wretch. I should die."

Instead of trying to dissuade him from such a conviction and resulting course of action, society simply echoes, "You are a miserable wretch. You should die."

Rehabilitation of the alcoholic depends upon his reeducation. It depends upon his being led to reevaluate himself and his inner resources so that he can acquire respect for both. Decisive results from such education are difficult to achieve for the reason that they must be accomplished in a sort of social vacuum.

It is not easy for the alcoholic to respect himself because self-respect thrives best when it is fed from sources lying beyond the individual's own personality. However, where the alcoholic is concerned, any positive self-regard he may develop is apt to be swept away in the floods of adverse attitudes flowing upon him from without. Alone, he cannot come about a more healthful concept of himself any more than he can lift himself by his own shoelaces.

The rehabilitation of the alcoholic, therefore, depends upon his having a source of self-esteem beyond the realm of his own personality. Special education provides this source. A program of special education constitutes evidence that not all of our society has despaired of him.

The program itself is proof that people believe him to be worth helping. The special educators or therapists can demonstrate in a personal way their own esteem for him, thus helping him to disregard the adverse, condemning, and depreciating attitudes which hover around him in his social situation. What others say of him or how they feel toward him becomes less devastating in the face of the positive program of special education.

In Alabama, there are from 40,000 to 50,000 alcoholics and from 120,000 to 200,000 individuals personally involved and deprived because of the illness of these people.

Throughout the Nation there are an estimated 5 million alcoholics and from 15 million to 20 million persons seriously involved and deprived.

The need for programs of special education and rehabilitation is made obvious from the above estimates and from the effectiveness of such programs, as demonstrated in various States.

In Alabama, the demonstrations have taken place in two clinics which are functioning under the auspices of the Alabama Commission on Alcoholism. Therapy administered in these clinics consists mainly of special education of the alcoholic and, whenever possible, of his relatives and acquaintances. As of September 30, 1959, a very high proportion of patients completing treatment in these clinics were considered to have had their conditions improved or arrested.

Alcoholism is generally regarded as one of the foremost health problems of the Nation. Yet, it can be effectively treated by special education programs. Heretofore, primary responsibility for these programs has been assumed by the various States and this is perhaps as it should be. With the limited tax resources which are available to the States, however, it has not been easy for some of them to finance

really adequate special education staff and facilities for effective programs. Indeed, some of the States, without Federal encouragement, have not progressed beyond programs of very general education with respect to alcoholism, and general education is not effective enough to restore alcoholics to social competence and vocational productivity.

Of not little importance is the alcoholic's need to realize that he is significant enough for the Nation to be concerned about him to the extent that the Congress of the United States assumes some responsibility for stimulating and perhaps coordinating the efforts of the various States to provide rehabilitation programs for him.

Prejudice against the acceptance of the alcoholic as a genuinely sick person, easily mouthed slogans to the contrary notwithstanding, is so widespread as even to permeate the ranks of professional people, with the result that the range of professional persons available to reeducate or to treat alcoholics is somewhat restricted even beyond the point to which they are restricted for other educational and therapeutic endeavors.

The State of Alabama has taken practical action to overcome this handicap by making available limited funds for the professional training of carefully selected persons to assume responsibilities for the reeducation or treatment of alcoholics. Of course, these persons cannot be kept within this State. The individual accepting a training stipend is morally obligated to work for a limited time within the State, but thereafter the probability is that he will be attracted to superior salaries elsewhere.

Therefore, this subcommittee might wish to consider the possibility of recommending to the Congress of the United States that some step be taken to encourage all the States to adopt training programs similar to that which is administered by the Alabama Commission on Alcoholism.

It is likely that through both general and special education combined with an adequate program of treatment, the profound and widespread problem of alcoholism can be diminished very much as the problem of tuberculosis has been diminished. However, it cannot be done with timid and halfhearted measures. Neither can it be done unless the States combine their efforts to launch a giant program on a nationwide basis.

Perhaps this subcommittee will be able to devise ways of encouraging the development of such a program while at the same time leaving responsibility for the local programs primarily in the hands of the various States.

Thank you.

Mr. ELLIOTT. Thank you very much, Mr. Sessions. I wonder, Mr. Sessions, if you might be willing to extend your remarks, to send us additional memoranda in writing, giving the range of the Alabama program for alcoholism and some of the details about it.

Mr. SESSIONS. I will be happy to do so.

Mr. ELLIOTT. Your testimony has been very impressive, so far as I am concerned, and I thank you.

Mrs. GREEN. I know the time limit, Mr. Chairman, but we have heard about the dearth of trained personnel in these other fields.

I notice by the paper that you are a psychiatric social worker. How many trained psychiatric social workers are there, for instance, in Alabama, where you do have a program?

Mr. SESSIONS. Are you asking about the total number of trained psychiatric social workers in the State or those employed by our commission?

Mrs. GREEN. I would like first the total number that would work in the schools and other areas.

Mr. SESSIONS. Being a relative newcomer to the State of Alabama, I am afraid I am not able to make a very reliable estimate regarding the total number in the State. I would guess it to be something like 20. There are more trained social workers, but probably something like that with the psychiatric sequence.

Mrs. GREEN. How many trained psychiatrists are there? Do you have an idea on that?

Mr. SESSIONS. No; I don't.

Mrs. GREEN. And you have 40,000 to 50,000 alcoholics in the State?

Mr. SESSIONS. Yes.

Mrs. GREEN. Then here is another area where the problem is really personnel?

Mr. SESSIONS. That is absolutely true.

Mrs. GREEN. You spoke that the commission apparently has a training program, and they go to other States where salaries may be higher. What is the salary that Alabama could offer in this area?

Mr. SESSIONS. The commission has also attempted to remedy our handicap with respect to the acquirement of personnel by having a somewhat more liberal salary than is usually found within the State. The beginning salary for a fully trained psychiatric social worker is \$6,000 a year. Unfortunately, we don't have much upward range from there.

If a person works 10 years, he may acquire \$1,500 a year more than that, this after the individual has had 2 years of graduate training in a school of social work.

Six thousand dollars a year represents not too good a return on his investment of time. But as compared with other social workers' salaries within the State of Alabama, it is very good.

Mrs. GREEN. You refer to the high percentage of cases that were improved, or where the alcoholism was stopped. What percentage is that, the one that you were speaking about?

Mr. SESSIONS. The last time we did a little research with respect to our Birmingham clinic, among those patients who had completed the treatment, 78 percent had been considered either improved or were considered to have had their conditions arrested. Of course, these terms are subject to definitions.

In order for us to have considered the person to have had his condition arrested, it would have been necessary for him to have been completely abstinent from alcoholic beverages for a period of at least 6 months and to have shown marked progress also in the areas of interpersonal relationships and vocational adjustments if at the time he came to our clinic progress and vocational adjustment were indicated as being needed.

If we close the case not as having this condition arrested but simply as having improved, it was necessary for him to have been totally abstinent for an impressive period up to or over 6 months, or maybe somewhat less than 6 months but not much less than that, and he might

not have shown the marked improvements in other areas to which I referred.

Mrs. GREEN. Thank you.

Mr. ELLIOTT. Thank you very much.

Our next witness is John S. Prickett, Jr., assistant director, rehabilitation services, Atlanta, Ga.

**STATEMENT OF JOHN S. PRICKETT, JR., ASSISTANT DIRECTOR,
REHABILITATION SERVICES, ATLANTA, GA.**

Mr. PRICKETT. Mr. Chairman and members of the committee, Dr. A. P. Jarrell, our State director, was invited to testify before your committee, but due to recent illness and upon the advice of his doctors, he was not able to come. He wrote Mr. Elliott, asking that I testify in his stead. I have a statement from him.

Mr. Chairman, and members of the subcommittee; it is a high privilege to appear before this distinguished committee on behalf of disabled people who need help in achieving economic and social independence.

At the outset I would like to say that vocational rehabilitation forces in Georgia endorse the provision of the pending bill to expand the services now provided under the joint Federal-State program; namely, H.R. 3465.

We also endorse House Joint Resolution 494.

The Georgia Rehabilitation Association, representing nearly 1,000 professional workers and lay people, recently passed a resolution supporting the provision of H.R. 3465. A letter reporting this action was sent to the chairman of your committee.

As to the need for such legislation, may I briefly outline the situation in our State.

During the past 5 years, more than 26,000 disabled civilians have been restored to productive jobs through the services of the joint Federal-State program of vocational rehabilitation. There has been a steady increase, year by year, in the number of rehabilitations for the past 10 years. Throughout a 5-year period, we have provided services to nearly 12,000 disabled persons annually.

At the end of the fiscal year 1958-59, there were 5,938 cases on the active rolls, still receiving services, and there were 8,450 applications for services awaiting investigation.

Moreover, there are thousands of other seriously disabled people who need services, which we are unable to provide because of the lack of funds, facilities, trained personnel, and because of legal restrictions.

The Office of Vocational Rehabilitation estimates that there are in the Nation about 2 million disabled persons who need vocational rehabilitation services and 250,000 annually who are becoming disabled. On this basis it is estimated that there are about 30,000 disabled people in need of vocational rehabilitation services in Georgia.

Under the support program, Georgia received \$2,222,889 of Federal funds during fiscal 1959. The State spent \$1,450,416 for the program, which was \$219,164 more than the amount required to match Federal funds. This year, 1959-60, we have nearly \$200,000 of State funds in excess of the amount required to match Federal funds.

As pointed out in our letter of June 22, 1959, to the chairman of this subcommittee, Georgia appropriates on a per capita basis more funds for vocational rehabilitation services than any other State in the Nation. There are several other States which are appropriating more funds than OVR can match under the present formula.

Therefore, we should respectfully urge that the allotment base be increased at least in an amount sufficient to give these States enough Federal funds to match the State funds available.

From our study of the formula for the distribution of funds for the support program, an allotment base of approximately \$85 million would be required. This would enable these States to expand their programs in vital fields.

We are hopeful that Congress will see fit to amend section 3 of Public Law 565 so as to permit the transfer of extension and improvement grants from those States which are unable to use them to States which have sufficient funds to activate projects under this section. This proposed change in the law would be helpful to the States which are financing adequately their part of the program.

Georgia is undertaking a tremendous expansion of its mental health program. It involves an expansion of facilities, staff, and services at the State hospital, a new hospital for the mentally ill in Atlanta, together with five additional treatment hospitals, similar to that now in operation at Augusta, Ga. The cost is estimated at \$15 million above that which is now being spent for the treatment of the mentally ill.

The Georgia rehabilitation agency is cooperating with the State department of public health and the State department of public welfare, hospitals, and other agencies in developing a coordinated rehabilitation program for mentally ill, emotionally disturbed, and mentally retarded persons.

Our counselors work with teams of specialists at several hospitals in planning rehabilitation services for mental patients and epileptics who ultimately may be returned to employment.

As the mental health program expands, additional counselors will be needed for this specialized service.

For the fiscal year 1958-59, the agency rehabilitated only 137 mentally ill persons. Currently we are providing rehabilitation services to about 400 individuals whose disability has been diagnosed as emotionally disturbed. The mental health program has the backing of the Governor, the legislature, and the citizens generally. It will offer a great opportunity and challenge to the rehabilitation agency to provide rehabilitation services to patients from these hospitals and centers. But more money will be required.

If more funds were available, we are confident that we could increase the number of rehabilitated patients among persons with mental handicaps threefold in the next 2 years.

I am of the opinion that H.R. 3465 represents a logical and constructive step in the development of the Nation's rehabilitation services. Year after year we are compelled to decline services to thousands of applicants who do not have the rehabilitation potential to qualify under the present law. Many of these people, we are certain, could be restored to some degree of self-sufficiency as envisioned under H.R. 3465, the independent living and rehabilitation measure.

As evidence of Georgia's interest in independent living rehabilitation, the general assembly at its 1959 session amended the State rehabilitation law to authorize this type of service. We are planning to put this measure into effect when appropriate Federal legislation is passed and Federal funds become available.

In Georgia there is a pressing need for more workshops and vocationally oriented rehabilitation facilities to serve more of the mentally ill, epileptics, mentally retarded, blind, deaf, cerebral palsy, and other seriously disabled individuals. There is a great need, especially, for work evaluation and diagnostic units within both rehabilitation facilities and sheltered workshops.

With such facilities we could rehabilitate many borderline cases which now are neither ready for rehabilitation schools nor competitive employment. This situation is another reason for our strong endorsement of H.R. 3465.

In Georgia, the school for the deaf is a unit of the vocational rehabilitation division. We know from long experience that it is difficult, if not impossible, to get specially trained teachers of the deaf to staff this school.

During the past 10 years, enrollment there has increased from 291 to 427, which shows the increasing need of well-qualified teachers.

Of scarcely less importance is the pressing, urgent need for psychologists, social workers, counselors, and other personnel. The ability of these professional workers to serve the deaf is seriously limited because of the lack of special training necessary for evaluating and meeting their needs. We know, too, that there is a shortage of trained audiologists and speech pathologists in the private agencies from whom we purchase services for our clients.

Frequently our clients with hearing and speech impediments are compelled to wait for weeks before appointments at these centers can be made. Enactment of House Joint Resolution 494 would in time help materially in remedying this shortage of trained personnel in this field.

We should be glad to have any members of this subcommittee or your colleagues in Congress visit Georgia and observe the operation of our vocational rehabilitation program.

I thank you, ladies and gentlemen, for the opportunity of appearing here today. If there are any questions, I would be glad to attempt to answer them.

Mr. ELLIOTT. Thank you very much, Mr. Prickett.

If there are no questions, we will give you our thanks, Mr. Prickett, for a fine statement.

May I at this point recognize the fact that Dr. E. A. McBride, president of the Alabama Institute for the Deaf and Blind at Talladega, Ala., is present, and to say to him that we appreciate his presence.

Do you care to say anything, Dr. McBride.

STATEMENT OF E. A. McBRIDE, PRESIDENT, ALABAMA INSTITUTE FOR THE DEAF AND BLIND, TALLADEGA, ALA.

Mr. McBRIDE. I do not want to take up the time of the people who have been invited here to testify. The testimony they have given fits our case exactly.

We are short of trained personnel, both as teachers for the deaf, counselors for the blind, and counselors for the deaf.

Dr. Ainsworth will bring our report from the 2-day meeting in Atlanta.

Mr. ELLIOTT. Thank you, Dr. McBride.

Also, I am happy to recognize the fact that members of a sociology class from Sacred Heart College of Cullman, Ala., are with us this afternoon, accompanied by their instructor, Sister Jerome, and Sister Martina, the principal of the Sacred Heart Academy.

May I also recognize the fact that Mrs. Jewell Davis, the tax assessor of this county, is with us this afternoon.

Mr. Raymond Higdon, tax collector of this county has also been with us today.

Our next witness is Mrs. Lillian R. Jones, State school for the deaf, Baton Rouge, La.

Mrs. Jones, you may proceed with our usual time limitation of 10 minutes.

STATEMENT OF MRS. LILLIAN R. JONES, STATE SCHOOL FOR THE DEAF, BATON ROUGE, LA.

Mrs. JONES. Mr. Chairman, Senator Ellender and Senator Long wired Mr. Patton, the superintendent, last Wednesday, advising him of this hearing and asking him to attend or to send a representative. Mr. Patton himself was unable to attend and he sent me.

Both Senator Ellender and Senator Long knew of Mr. Patton's deep interest in the future education of deaf children, because of the present extreme difficulty in securing and retaining—

Mr. ELLIOTT. May I interrupt you?

I see that Hubert Coker, president of the Alabama Welfare Society, twice president, is leaving. May I say to him that we are sorry the time has come that he has got to leave us. He is accompanied by Mrs. Geneva Thurman who, working with him and through the Veterans of Foreign Wars, has done so much to promote that phase of our handicap work in Alabama.

You may proceed.

Mrs. JONES. I am speaking primarily in behalf of the education of the deaf. In this area of special education, we are seeking no enlargement of the base of our operations, but we are deeply concerned in maintaining and improving the services which have been offered American deaf children for more than 150 years.

We see the grave possibilities of a serious decline in the quality of these services because of the lack of trained personnel.

I have read reports which others have made to this committee and there is no need for me to go into the statistics which the others have previously given you. But the shortage, which is nationwide, is particularly acute in the South, because of the traditionally lower salary schedules.

In this regional hearing, may I tell you of our situation in Louisiana?

The State school for the deaf in Baton Rouge is one of the medium sized of the southeastern schools for the deaf. It has an enrollment of around 310 and educational staff of 51. Our salary schedule

compares favorably with the salary schedules for most of the schools for the deaf in this region, but not one normally hearing teacher, trained or untrained, has applied for work in that school for the past 2 or 3 years.

Such normally hearing teacher replacements as we have been able to secure have been teachers who have been formerly on our teaching staff that we impressed into service again, or teachers that had retired from public school systems to rear families or for some other reason who wished to return to their public school teaching again. When we hear of such an interested teacher, whom we know to be competent, we try to interest them in making application for teaching in our school.

Over the past several years the Louisiana school has been able to add the services of only three qualified trained teachers of the deaf, qualified to teach oral and written communication skills, who were not previously employed at the school.

One of these came to us because her husband was working on his doctorate in speech at the State university. Another retired from a northeastern school, came south looking for a warmer climate, and within 2 years moved yet further south. A third Mr. Patton was able to secure because this man's family was formerly a superintendent in that school.

As our teachers have retired or left for other schools, their places have been filled by urging former teachers in the school now living in the community to return to classroom work again. But this supply of trained local teachers is now exhausted. As teachers leave the Louisiana school at present, they are of necessity replaced by former teachers in the public school system, wholly untrained for this special work, however in earnest they may be.

In-service training is attempted by an already overbusy staff. The children themselves are the losers. Until the more recent years, needed replacements have been few, and we have not had to employ many such teachers. But at present we are keenly conscious of the fact that there are no more trained teachers available to us, and many of our teachers are at present fast reaching the retirement age. Within the next 10 years, most of the trained teaching personnel which we now have will have been retired.

Our enrollment has increased over 10 percent this year, and most of this increase is in the beginning classes. This is an unusual situation for us, where we usually get a good many overage pupils, who cannot make the public school situation. The group of 30 small children we received this year will remain with us for 12 to 15 years, and we are considerably concerned over the possibility that they will not be as well taught as the pupils who had been formerly enrolled in the school.

Without more trained teachers, the status of the deaf over the next generation will deteriorate immeasurably. With a good education, provided by qualified teachers, the deaf become self-respecting, self-supporting, taxpaying citizens, asking no special favors at the hands of the State. Indeed, as a national group, State by State in conventions 2 and 3 years ago the deaf rejected the idea of any special exemption on their income tax, an exemption that could have been added because of their hearing impairment. Half-educated or un-

educated, many of the deaf of the next generation would become welfare cases, wards of the State.

We feel that the legislation as proposed in your bill, Mr. Elliott, will make the optimum education available by providing the necessary trained teachers.

May I thank you for giving me the opportunity for bringing this to your attention, and to express the hope that your efforts on behalf of the hearing impaired and the speech handicapped will bring into these areas the trained, well-qualified teachers and other personnel who are so badly needed.

Mr. ELLIOTT. Thank you very much. Are there any questions?

Mrs. GREEN. You spoke of the low salaries, and you were not able to recruit the teachers you wanted. What is the beginning salary?

Mrs. JONES. We work on the State minimum salary schedule. The State fixes our salary. It is in the process of being implemented this year.

Do you know, I do not have much to do with that in our school. I am the principal. I can give you the figures from 1958, if you will give me just a minute. I can furnish you that on request.

The position in our school is unusual, unfortunate, in that the teachers in the State schools are paid on the State minimum salary schedule, while the teachers in several of the Louisiana parishes are paid the minimum salaries plus an implementation that is paid by the local parish. We have parishes, not counties, in Louisiana.

I am sorry, but had I known you were going to ask that question, I would have had the information available.

Mrs. GREEN. Would you rather submit it for the record?

Mrs. JONES. Yes, I will be glad to do that.

Mrs. GREEN. Fine.

(The information referred to follows:)

Requested salary schedules for certain teachers in Louisiana

	B.A. degree		M.A. degree	
	Minimum salary (no experience)	Maximum salary (12 years' experience)	Minimum salary (no experience)	Maximum salary (19 years' experience)
State school for the deaf: State minimum salary.....	\$3,250	\$5,200	\$3,425	\$6,000
Parish (county) where State school is located: State minimum salary schedule plus across the board \$300 increment.....	3,550	5,500	3,725	6,300
Orleans Parish: 1 State minimum salary schedule plus increment (regular classroom teachers and teachers of special classes have same salary).....	3,490	5,664	3,818	6,446
Caddo Parish: State minimum salary schedule plus increment.....	3,650	5,600	3,825	6,400
State minimum salary schedule plus increment plus differential for teachers of special classes.....	3,925	5,875	4,100	6,675

¹ Orleans Parish also provides salary schedule for nondegree teachers who are 2-year normal school graduates on a temporary basis in this category, paying a minimum salary of \$3,340 for no years of service and a maximum salary of \$5,514 with 12 years service.

Mr. QUIN. What kind of teachers do you have the most difficulty finding, the ones that teach shop and vocational courses, or the ones that teach your academic courses?

Mrs. JONES. The fact of the matter is that the vocational teachers, while we would prefer trained teachers of the deaf for that, most

of their teaching is in the line of showing and they do not need the language training.

It is the oral teachers, the teachers qualified to teach speech and lipreading and keep the speech up, teaching the communicative skills.

The largest problem with the education of the deaf is the building of adequate means of communication at successively higher levels of integration. Our main trouble through the whole school, through any school for the deaf, the hardest problem, is the teaching of language, not speech or not reading.

Mr. QUIE. The second question is this: Are there any classes for the deaf in public schools in Louisiana?

Mrs. JONES. They have one in the New Orleans public school system and they have two or three in the Shreveport situation.

The Shreveport situation started out rather large, but I believe has become rather small. The speech and hearing center at Tulane employs a preschool teacher, but I understand that preschool teacher is not a trained teacher of the deaf. I do not know what he can do with deaf children.

Mr. QUIE. When you submit the salary schedule, could you give us also the salary of those in public schools? That is, if you have access to that.

Mrs. JONES. We can do that. Ours is the minimum public school salary.

Do you wish also the added amounts that are paid to the teachers of the deaf in the Shreveport schools and in the New Orleans schools?

Mr. QUIE. Yes. I think this is happening in many States, where the teachers in the State residential schools are paid considerably less than those in public schools.

Mrs. JONES. We are on the minimum State salary schedule.

Mrs. GREEN. Can you estimate what that is?

Mrs. JONES. I can give you the maximum, because I can subtract and get my own salary. The maximum, the greatest amount that a teacher can get after many years of service and a master's degree would be around \$6,200 or \$6,400. They are implementing that within a year or two. There are schools who pay less.

Mrs. GREEN. We have a shortage in our State. We will have some of them come down here and recruit.

Mr. ELLIOTT. Thank you very much, Mrs. Jones.

Now I will call Mrs. Marian M. Lee, National Society for the Prevention of Blindness, Asheville, N.C.

Is Mrs. Lee present?

If not, I will call Mr. William P. Turner, director, the Workshop for the Blind and Disabled, Inc., Birmingham, Ala.

STATEMENT OF WILLIAM P. TURNER, DIRECTOR, THE WORKSHOP FOR THE BLIND AND DISABLED, INC., BIRMINGHAM, ALA.

Mr. TURNER. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Turner, you may proceed, subject to our 10-minute limitation which I must start enforcing.

Mr. TURNER. Mr. Chairman and members of the committee, I have read the Rehabilitation Act of 1959 proposed by Congressman Elliott, and I certainly would like to support this program as a whole.

One part I would like particularly to comment on is the part dealing with workshops and rehabilitation facilities.

It is my belief that a community should be allowed to raise money which would be matched by the Federal Government, provided this was approved through the State vocational rehabilitation service and had the approval of the State agency, not only for the expansion and improvement of existing facilities, but for the construction and equipping of new buildings.

I would like for the law to provide for not only an initial staffing of facilities, but for the staffing on a continuing basis, to be matched by local facility funds.

I would like to see surplus property made available to workshops or approved facilities where Federal money is being used.

As director of the workshop for handicapped people, I consider one of our greatest needs to be for adequate equipment, to carry on the operation and evaluation program. Many of our people in workshops probably will never go back into employment in competitive industry, due to the nature and severity of their handicaps.

However, with a small amount of help, these people are able to live their lives as useful citizens in their respective communities, to own their homes, educate their children, pay their taxes, and live a near normal life, despite their handicap. However, some form of subsidization is necessary, because very few of these people reach what you would call top or normal efficiency in any job.

Jobs for these people must be carefully selected and people thoroughly trained. Many times, with adequate training, adjustment and orientation, these people are able to go into competitive industry without asking aid from anyone. Both in our training and terminal employment there is a need for additional equipment, maintenance of present facilities and expanding job opportunities; namely, the manufacturing of switchboxes. We are engaged in the manufacturing of switchboxes as one of our projects now. Those are the boxes you have on the wall for switches. We need drill presses, lathes, milling machines, shapers, welding machines, and other equipment, much too expensive for us to dream of buying, especially when the cost of such equipment would be paid for out of earnings produced or created by severely handicapped people.

Vocational schools, one of which I was associated with for the past 10 years, are doing an excellent job training our young people and adults for the various highly skilled trades, also under the fine education bill sponsored jointly by yourself, Congressman Elliott, and the Honorable Senator Lister Hill. However, these courses consist of complete trade training, requiring from 2 to 6 years to complete.

Their goal is to graduate a journeyman technician or specialist in a particular field and trade chosen by the student. There are certain physical and educational requirements these people must meet as a prerequisite to enrollment in these courses. The people in our workshop couldn't meet these combined requirements, in many cases neither requirement, but there is an area in which these people can be trained and employed: that is, a semiskilled job, where they learn to do one or a few simple operations on one machine. Some of these jobs would be classified as drill-press operators, turret-lathe operators, grinders, shapers, or milling machine operators, punch-press operators, and

many such jobs, where no close tolerances are necessary. Much less training is required for these jobs.

I feel the workshops for handicapped are in an excellent position to develop these fields of training. Most of the equipment needed in the workshops could be secured through the Health, Education, and Welfare agency of our Federal Government if we were made eligible to participate in securing surplus property.

Many of our handicapped people are young enough today to probably see the anticipated tremendous shortage of workers in the not too distant future and have a part in lessening this shortage through training they receive in workshops.

Another great need in workshops is some source for a steady flow of work. One way of meeting some of these needs is the opportunity to bid competitively on small Government contracts handled through the Small Business Administration, ordnance procurement offices, military installations. Many of these jobs consist of sewing, packaging, labeling, sorting, collating, light manufacturing and fabrication.

In many instances, the workshops already have the know-how and the facilities to do these jobs.

I believe that is all I have to say.

Mr. ELLIOTT. Thank you very much, Mr. Turner.

Are there any questions of Mr. Turner?

Mrs. GREEN. Is this a private agency that you represent?

Mr. TURNER. It is sponsored jointly through the community chest and under the supervision of the rehabilitation association. It is a nonprofit organization. The small subsidy we get is from the community chest.

Mr. GIAIMO. Do you get any funds from the State?

Mr. TURNER. The only funds we get from the rehabilitation agencies are for training, training or some evaluative work that we do. They put them in as students and they pay us a tuition for that. That is the only thing we receive.

Mr. GIAIMO. Other than that, is the income on your own products?

Mr. TURNER. We get it from the work we do in the shop; yes, sir.

Mr. ELLIOTT. Thank you very much, Mr. Turner. Your testimony has been very helpful. We appreciate it.

Our next witness is Mrs. Bess Bains, attendance supervisor, Blount County public schools, Oneonta, Ala. Is Mrs. Bains here?

If not, our next witness is T. Euclid Rains, trustee, Alabama Institutions for the Deaf and Blind, Albertville, Ala.

STATEMENT OF T. EUCLID RAINS, TRUSTEE, ALABAMA INSTITUTIONS FOR THE DEAF AND BLIND, ALBERTVILLE, ALA.

Mr. RAINS. Hon. Carl Elliott.

Mr. ELLIOTT. Are you related to Congressman Albert Rains?

Mr. RAINS. No, I am sorry to say I am not. He is a good friend, though.

Mr. ELLIOTT. You come from his area, I notice.

Mr. RAINS. Yes, sir; we are both from Bucks Pocket.

Mr. ELLIOTT. When did you move to Rainsville?

Mr. RAINS. Some time ago.

I have been here since early this morning and very much of what I would say to your committee has already been said. I think that it is self-evident that a need for help for the handicapped of the South is urgent.

I would like for you to remember this one thing: Jesus Christ once said, "For you have the poor always with you," and in your work back in Washington I would like for you to remember that "Ye have the handicapped always with you."

When I was in college, I had a psychology professor who told us a little anecdote which I think pretty well sizes up the needs of the handicapped here. He said if you have to take a piece of wood and borrow a knife, you could whittle as good as anyone could. What he meant was, if you had tools and material to work with.

As you know, we have the material, and what we really need here are specialized tools to shape this material into useful citizenry.

I am primarily interested in the education of the blind and deaf, and also I am interested in vocational rehabilitation with respect to the agricultural angle. In a psychology class once I remember it was said that a blind person is 85 percent handicapped. That is saying that 85 percent of what a person learns comes through his eyes. Therefore, blind people are, you might say, 15 percent efficient.

With this great deficiency of something to offer or something to learn a trade, job opportunity is lessened a great deal.

When I finished college—I made pretty good grades—I couldn't find any work. I had looked around my part of the State and I believe that job opportunities for a totally blind person are about 1 percent of those of the average high school graduate, notwithstanding my college education. That was how I felt.

Today the vocational rehabilitation program in our State has hired, trained, sent to college and then turned around and hired these people, for the reason that we don't have enough funds or enough liberalized legislation to train people in fields that will enable them to go into competitive areas or to enter themselves into the market of labor, along with the society work.

Back several years ago, and some of this is still with us today, when you left an institution for the blind in the South, they said, "Young man, go make a broom." But no longer do we have the kerosene lamp economic complex. Today we are in a modern age, with high expenses, and the demands for everyday living are so high and so expensive that education has become very important in even a blind person's life.

Blind people can be really useful. You will remember that "Paradise Lost" was written by a blind man, and a blind man discovered the mating cry of the queen bee. Blind people, some of them, are filling very high places. Some of them have walked on Pennsylvania Avenue. But the average blind man might not have sufficient ambition to reach these high goals, and he is the man that we want to reach.

The School for the Deaf in Alabama has five teachers retired. Some of these teachers have been with us for as much as 30 years. They are almost indispensable. It is very difficult, in spite of the favorable salary scale, to get someone to come in to teach, who can teach, who is qualified to teach deaf people.

The president of the institution is constantly reminding us, the board, of the great need for specialized teachers. Also, as I am associated with the rehabilitation officials of the State, they are also reminding us that, in telling us that, they need specialized people, specialized trained personnel, and special equipment, and that they need certain legislation modified or liberalized so that they can better and more effectively carry out their program to the best advantage of the handicapped of the State.

Mr. ELLIOTT. Mr. Rains, I am going to have to interrupt you right there, as your time is up. But I will ask you if you will do this: Will you send us the remainder of your statement within 2 weeks from today and let us include it in our record?

Everything that has been said today is being taken down. Statements that are not completed we put into the record and have all of the material for the use and benefit of the members of the subcommittee. If you would do that with the remainder of your statement I would appreciate it.

Mr. RAINS. I will be happy to do that.

Mr. ELLIOTT. Thank you, sir.

(Prepared statement of Mr. Rains follows:)

STATEMENT OF T. EUCLID RAINS, TRUSTEE, ALABAMA INSTITUTES FOR DEAF AND BLIND

In conclusion, I would like to urge the passage of H.R. 3465 and House Joint Resolution 494. I would like to restate here that in the institutions for the deaf and blind here in Alabama, especially the institution for the deaf, that there exists a great need for specialized instructors in many areas. For example, qualified personnel in the area of speech therapy are extremely difficult to obtain and physical education instructors for the blind are likewise scarce.

In my opinion, the deal is not yet dealt for the handicapped in this country but the work only has just begun and now awaits some stalwart who will help to bring down the ironic barrier of limitations that has heretofore crucified so much "handicapped" ambition and ability on a cross of charity. I believe that the passage of the aforementioned bills will help in no little way in achieving a higher standard of living for the handicapped here in Alabama. I think that this will open new doors of opportunity to numbers of our handicapped who were heretofore denied a fuller measure of independent living by the "padlocks" of poverty and lack of education. In short, it will help us who work with the handicapped toward the realization of an ancient dream—namely, farewell to welfare.

Mr. ELLIOTT. Our next witness is Mr. Gentry.

Mr. Gentry, you are an Alabama man. Would you mind, since we have these people from Atlanta, possibly being with us tomorrow?

Mr. GENTRY. Yes, sir; I am sure I could come back tomorrow. I am with Mr. McBride.

Mr. ELLIOTT. Are you traveling together?

Mr. GENTRY. Yes.

Mr. ELLIOTT. Well, you are nearly to Atlanta yourself. Have a seat and proceed with your statement.

STATEMENT OF E. H. GENTRY, DIRECTOR, ADULT BLIND DEPARTMENT, ALABAMA INSTITUTE FOR DEAF AND BLIND, TALLADEGA, ALA.

Mr. GENTRY. Mr. Chairman and members of the committee, I think I can get through with what I have to say in 5 minutes.

May I be permitted first of all to give the committee as background information my area of interest?

I am the administrative assistant to the president of the Alabama Institute for the Deaf and Blind, with responsibility for the direction of the Department of Adult Blind, with all services to the blind which makes up that program; director of the Comprehensive Center for the Deaf, and director of Vocational Education.

The development of facilities which we have in our State institution represents the joint efforts with the State division of rehabilitation. Vocational education programs in the school provide training for both inschool and out-of-school deaf and blind.

We are able to move out within the framework of the present Federal legislation with the following exceptions, which I wish to emphasize: No. 1—I will not take the time to emphasize this further, as all of us who have been here today have heard the excellent presentations on the need for more and better trained personnel.

The needs are so great there that we could keep on talking about that. But the staffing of rehabilitation centers for the deaf and blind is equally as important as development of staff or of teachers for the classroom work in special fields of special education.

I would like, Mr. Chairman and members of the committee, to make two or three suggestions, possible suggestions.

I would like to suggest that possibly the present Federal Rehabilitation Act be amended to legalize the expenditures for construction of some much needed facilities. As the law now stands you have to improve or add to an existing facility. It may be better to move the facility 20 feet away from the building, but you cannot do it. The limitations in the Federal act now certainly work a hardship in some cases.

I would like to see the Federal act liberalized for periods of evaluation and diagnosis, particularly in the field of the deaf and blind, to be more liberal than now. I would like to see it liberalized to allow payments while the person is out on job trial experiments in rehabilitation.

I am particularly concerned and interested after exactly 30 years this May 1 in the field of special education and rehabilitation, and with the State institute for the deaf and blind, about this one area of legislation known as the Independent Living Act.

I think we have gone far enough piecemeal, Congressmen, in this whole field of rehabilitation. I think we have been adding to, ever since, to my certain knowledge, 30 years, which has been fine, but we have to do the job right or quit doing a piecemeal job as we go along.

I think this independent living rehabilitation measure would permit many services, even through our home teaching program for the blind in Alabama. I will not take the time to read these, but I will provide those services that may be rendered, if that proposed legislation is made into law.

I would like to close by saying that I am in full accord with all the things that have been discussed by our groups interested in all of these areas of special education and rehabilitation that will be presented here, but there is one thing that may not be included in that, and that is the whole area of talking-book machines and reading materials as provided through the Library of Congress.

We have had in the last 5 years in the development of a comprehensive center for the blind in Alabama under the Adult Blind Department Act a good many difficulties in serving the blind in the State through the home teaching program and through the training program.

Over 400 blind have come through that center for diagnosis, evaluation, vocational training, and followthrough back on the job. A little more than 300 of them are self-supporting today. But I am here to say to you that the services rendered have been meager. They haven't been anything like what they should have been, to really establish them.

For example, as a result of a 3-year demonstration project in rural pursuits in the field of agriculture in Alabama, which has just been completed, in which six farmers were placed on farm production units, as a result of that there have been 18 additional farmers established.

But did you know that even though we bring them to the institute, through a demonstration farm we are able to teach them how to operate a poultry house, and when they go back home rehabilitation funds cannot be used to provide that egg laying house? I say to you that we need rehabilitation liberalized in order to serve these people.

Thank you.

Mr. ELLIOTT. Can blind people be rehabilitated to operate these cage-laying operations efficiently?

Mr. GENTRY. Yes, sir. We have 18 of them in Alabama today doing it.

Mr. ELLIOTT. Thank you very much.

Our next witness is Miss Vera J. McClain, home teacher and counselor for the blind, Adult Blind Department, Alabama Institute for Deaf and Blind, Birmingham, Ala.

Miss McClain, you may proceed in any manner that you desire. I regret that we must limit you to 10 minutes.

**STATEMENT OF VERA J. McCLAIN, HOME TEACHER AND COUNSELOR
FOR THE BLIND, ADULT BLIND DEPARTMENT, ALABAMA INSTITUTE
FOR DEAF AND BLIND, BIRMINGHAM, ALA.**

Miss McCLAIN. Well, like most women, I can talk a lot longer than that.

Congressman and members of the committee, it is a real pleasure for me to meet with you here today in Cullman, mainly because this is my hometown. This is where I graduated from Cullman High School in 1946. Then I went blind the following year. I went to the school for the blind as a special student for a year to learn what blind people did in the way of work and how they lived and things of that nature.

Then it has been my good fortune to go to Alabama College and be a graduate from that fine school and earn my degree in social work. In addition to that, I have been to the University of Pennsylvania and had training in adult blind education, and to Boston University for training and work with the emotionally disturbed. Finally I got my master's degree from Hunter College, in rehabilitation counseling, where I had the good fortune of having Dr. Frampton as one of my instructors.

Today I would like to talk of my experiences, having 6 years in the field of work with the blind, and these are some of my observations which I have picked up. This experience was drawn in part, probably, from some of the insight I have had in my professional training.

Some of these points I did not hear mentioned in Atlanta, and there are things that I thought about during the night which I feel have to have some consideration. So I got up this morning and rewrote my whole speech. I haven't had time to correct it, but anyway, I will go through and try to bring out these points as best I can.

No. 1. I do not think we can stress too much the need for the enactment of H.R. 3465. Being interested in the field of work for the blind, most of my remarks here today will pertain to the blind.

Whereas fully half of the Nation's blind population is estimated to be in the older age range; and whereas, a large proportion of the blind population between the ages of 16 and 65 are severely limited by other disabling conditions which render them unsuceptible or ineligible for rehabilitation services under current regulations, I hereby give my full suport for the enactment of the aforementioned bill.

It is felt, for example, that the provision of competent instruction and practical skills in conjunction with other rehabilitation services, where no vocational objective in competitive, gainful employment is indicated, that these people may be unable to achieve a certain amount of independence in the performance of daily demands and in personal adjustments to render them independent enough that some other member of the family unit who may be necessarily encumbered at the present time as an attendant may be relieved for an opportunity for employment outside the home.

I think this point has been brought out before, but certainly it is well worth mentioning again and again.

Point No. 2. This is a problem which we feel is a very urgent problem here in Alabama, and I am not sure how it has been felt over the Nation, but I want to bring it out. We need more liberalized legislation as it pertains to blind recipients of public assistance enrolled in rehabilitation training programs. It has been our experience here that in Alabama, for example, after a blind person has been enrolled in training at our adult blind department's training center in Talladega, which in most instances requires the blind person to leave his family at home in another county, that his public assistance in accord with current regulations is drastically reduced or in a lot of instances even cut off after 2 months, which obviously jeopardizes the welfare of his dependent family back home and seriously impairs the effectiveness and the acceptance of the comprehensive training made available through vocational rehabilitation sponsorship.

I feel that this is an urgent problem which certainly deserves consideration by this committee.

No. 3. And this is the point which Mr. Turner brought out, but I have it in my notes and I am concerned also, the erection of new workshop buildings and other rehabilitation facilities.

As we who are familiar with Public Law 565 know, it does provide for extension and improvement of already existing facilities. But we feel this should be amended to the effect that new buildings could be erected, say, using money which would be raised in the community, matched by Federal funds, to erect a new building in cases where it

was felt to be necessary, and it would be helpful toward rehabilitating more people.

No. 4. We need the development and expansion of employment opportunities for the blind. In view of the fact that most of the professional rehabilitation personnel in this country are felt to be limited by the lack of engineering and other scientific and technical skills, confronted in competitive industrial placement and workshop subcontract procurement, to make the broader and ever-increasing need for blind people for really substantial employment, it is deemed important that the Federal Government give some consideration to the employment of industrial research firms, such as Southern Industrial Research of Atlanta, to come into cities like Birmingham, for instance, and help us in the development of work opportunities and subcontract procurement.

This relationship would be one which would be probably a lot more meaningful, since these people from the industrial research organizations could assess the abilities of the blind, and things like that, through studies which they might have to do to readily make their assessment, and also so that they could talk and learn a great deal about work for the blind and what blind people's skills are.

Then they could go out to industry and really talk to industry about things that most people in rehabilitation just do not have the skill or knowledge to talk about in some cases.

With the support of the Federal Government, we feel that such an organization as Southern Industrial Research might be meaningful in helping us to develop and expand opportunities. This is something that needs study and development in itself, but it is a good idea to consider.

Mr. ELLIOTT. Thank you very much, Miss McClain.

(The following statement was submitted by Miss McClain:)

STATEMENT BY VERA J. McCLAIN, HOME TEACHER AND COUNSELOR FOR THE BLIND, ADULT BLIND DEPARTMENT, ALABAMA INSTITUTE FOR DEAF AND BLIND, BIRMINGHAM, ALA.

I am pleased to have the opportunity of participating in the activities of the congressional study of special education and rehabilitation and equally pleased to express my views with regard to unmet needs on this occasion here in my hometown. You will be interested to know that I have been blind since shortly after graduation from Cullman High School in 1946. After attending the school for the blind in Talladega, as a special student, I developed an interest in professional services for blind people and in preparation for this objective I earned an A.B. degree in social work from Alabama College, Montevallo. I had further professional training at the University of Pennsylvania and Boston University. I have an M.S. degree in education, specializing in rehabilitation counseling, from Hunter College where it was my pleasure to have Dr. Merle Frampton of this committee as an instructor. I have had 6 years of experience in services for the blind as an employee of the Adult Blind Department of the Alabama Institute for Deaf and Blind, Talladega, and most of my remarks today will be relative to services for this particular disability group.

1. Full support of H.R. 3465: Since fully half of this Nation's blind population is estimated to be in the older age range, and in view of the fact that a large proportion of the blind population between the ages of 16 and 65 are severely limited by other disabling conditions which render them unserviceable or ineligible for rehabilitation services under current Government regulations, I hereby offer my full support for the enactment of the aforementioned legislation. It is felt, for example, that the provision of competent instruction in practical skills, in conjunction with other rehabilitation services, where a vocational objective in competitive gainful employment is indicated, may enable these people to acquire

a renewed sense of dignity and to achieve adequate personal adjustment and independence in the performance of daily demands so as to dispense with the attendant services of another member of the family unit, who may as a result, be able to accept or return to employment outside the home.

2. More liberalized legislation as it pertains to blind recipients of public assistance engaged in a rehabilitation training program: It has been our experience here in Alabama, for example, that after a blind person has been enrolled in training at our adult blind department's training center in Talladega, which in most instances requires the blind person to leave his family at home in another county, that his public assistance in accord with current regulations is drastically reduced or terminated after 2 months, which jeopardizes the welfare of his family back home and seriously impairs the effectiveness and his acceptance of the comprehensive training program made available through vocational rehabilitation sponsorship. It is felt that this is an urgent problem which deserves careful study and prompt attention.

3. The erection of new rehabilitation facilities: Public Law 565 should be amended to the extent that local money can be matched with Federal funds for the erection of new rehabilitation facilities rather than being limited to current extension and improvement provisions of the law.

4. Development and expansion of employment opportunities for the blind: Inasmuch as most of the professional rehabilitation personnel in this country are limited by lack of engineering and other technical and scientific skills confronted in competitive industrial placement and workshop subcontract procurement to meet the broader and ever-increasing need of blind people for substantial employment, it appears advisable that the Federal Government should consider the employment of an industrial research resource; i.e., Southern Industrial Research of Atlanta, to provide their assistance in making more effective meaningful surveys of untapped employment possibilities.

Mr. ELLIOTT. Our next witness is Mr. William G. Wolfe, professor of educational psychology, University of Texas, Austin, Tex.

STATEMENT OF DR. WILLIAM G. WOLFE, PROFESSOR OF EDUCATIONAL PSYCHOLOGY, UNIVERSITY OF TEXAS, AUSTIN, TEX.

Dr. WOLFE. Mr. Chairman and members of the committee, may I take this opportunity, please, to thank you for your kind invitation of January 11 inviting me to testify at this hearing.

I am professor of educational psychology and director of the program of special education at the University of Texas, in Austin. I would like also for the record to state that I am State president of the United Cerebral Palsy of Texas.

In the interest of the time, I would like to present my discussion in a very succinct manner, stating a problem as I see it. You asked for urgent needs. I, of course, could not list all of them. I would like to list those I consider to be most urgent. Then I would like to follow a statement of the problems with a suggestion for the committee's consideration.

Problem No. 1: The care of the severely disabled person who is not able to maintain himself, is not mentally retarded but has no one to care for him. This, members of the committee, is a severe problem.

I offer as a suggestion for your consideration the provisions through Federal legislation for facilities for long-term care, in which the individual may live, be happy, et cetera. May I point out that we are not recommending just a custodial care institution. I would hope, and therefore suggest, that this particular facility be empowered to receive moneys from endowments, from private sources, et cetera.

I say this in passing: There are many families, quite wealthy, as a matter of fact, who would be more than happy to make endowments

available to institutions of this kind if they could assure the care of their severely involved child. I am thinking mainly of the cerebral palsied child in this instance.

Problem No. 2: The care of the very young severely mentally retarded or physically disabled child. As possibly you know, many States have no facilities for such children below the age of 6 years and parents can only provide for these children in private facilities.

But as you also know, most parents cannot afford this type of facility for their children.

Suggestion: States should be encouraged to lower minimum ages, and, when necessary, funds should be provided for the purposes of enlarging existing facilities to permit the lowering of this minimum age and, thereby, the taking of these children.

Problem No. 3: Many patients in custodial care facilities could be maintained in home environments if proper facilities were available to them in activities for daily living.

Suggestion: Legislation authorizing the Office of Vocational Rehabilitation additional funds to include this type of client in the program. I am thinking, sir, of your bill, H.R. 3465.

Problem No. 4: Because of lack of diagnostic facilities throughout the South available to schools and rehabilitation programs, many children are not properly classified and, as a result, many children are not receiving a proper clinical and/or educational program.

Suggestion: Legislation providing funds for the training of and employment of diagnostic personnel, such personnel as psychologists, social workers, et cetera. I might add that these particular personnel should be especially trained to do jobs for these particular types of deviate individuals. These funds should be allocated to the vocational rehabilitation departments and special education departments.

Problem No. 5: Lack of availability of properly trained personnel in the areas of crippled children, the deaf and the hard of hearing, the blind and the partially seeing, the area of speech therapy, psychology, social work, physical and occupational therapy.

Suggestion: Graduate fellowships from the Department of Health, Education, and Welfare similar to the present graduate fellowship program in the area of the mentally retarded. I am at a loss, if I may have the privilege of stating this, to understand why it would be deemed feasible to have graduate fellowships in just one area of exceptionality and not in the others. I, as a professor in a university with all areas, find it very difficult to comprehend this.

We have need for other areas, ladies and gentlemen. We appreciate very much the fellowships we have in the area of the mentally retarded, but we would like to have others in the other areas.

Problem No. 6: Lack of ability of many educational programs to properly enrich their curriculum in many of the areas of special education for the purpose of providing a program for the above-mentioned personnel.

Suggestion: Training grants from the Federal Government to those institutions wishing to go into this program. May I strongly add, only to those institutions who present evidence first of a desire to do this work; secondly, institutions which have necessary laboratory facilities in their community to provide practice teaching and clinical

practice opportunities as well as observational opportunities for their students.

Problem No. 7: Lack of proper liaison between special education, vocational rehabilitation, the Children's Bureau, child welfare, et cetera.

Suggestion: A joint committee be appointed at Federal, State, and local levels, with representatives from each service to function when programs, grants, policies, et cetera, are discussed affecting the exceptional children. At present I understand that there are 33 Federal departments contributing financially toward deviate children. I also understand that these agencies spend over a quarter of a billion dollars. I feel that a study should be made of this.

My last point is research. The problem: I personally feel that there is a lot of waste, many times in terms of money, time expended, as well as good data, in our present setup.

Suggestion: No. 1, coordinate medical and paramedical research and cut down on duplication; No. 2, place specialists from the specific fields in which the research is being attempted on the review panels at the Federal level.

If I may say one thing about that, in the review panels I would hope that there would be a specialist on this review panel from the area in which the research is being contemplated, so that better understanding might be afforded to the planning for this research.

Item 3, create a research data pool. As chairman of the medical professional board of the United Cerebral Palsy of Texas, I have learned from many physicians, outstanding neurosurgeons, et cetera, that many physicians, centers, schools, et cetera, are doing research, have available data, but do not have the time and general resources to make these data available to the general field through publication.

It is their feeling and mine that a research pool might be considered into which data might be placed and then a team of research specialists would look at these data, coordinate these data, and much wealth would come not only in terms of service, but planning for many years ahead.

In closing, I think there is a tremendous need to expand services. I also feel that there is a possibility for saving money in certain areas of this area of special education and rehabilitation by combining services.

If we can do this, this saving of money, we can take this saving and place it into the area of expansion.

With your permission, I would like to, at the request of the medical professional board of the United Cerebral Palsy of Texas, place in your hands, if you will allow it, a survey that was made of cerebral palsy in the State of Texas. This is a very comprehensive thing. It tells the need in this particular field. I would like to submit this, if I may.

Mr. ELLIOTT. Without objection, the material referred to by Dr. Wolfe will be made a part of the committee files.

Dr. WOLFE. May I say, too, sir, that I appreciate this high privilege of appearing before you.

Mr. ELLIOTT. We are honored to have you appear, Dr. Wolfe. Thank you very much.

Our next witness is Dr. Mamie Jones, director of special education, State department of education, Atlanta, Ga.

Let me say that after Miss Jones is finished, we will recognize Dr. Frampton to introduce our witnesses who have come directly from the workshop in Atlanta. After Dr. Jones' testimony we will take a 5-minute recess, and we will be ready to start with the workshop witnesses at 4 o'clock.

STATEMENT OF DR. MAMIE JONES, DIRECTOR OF SPECIAL EDUCATION, STATE DEPARTMENT OF EDUCATION, ATLANTA, GA.

Dr. JONES. Thank you.

Mr. Chairman and honorable members of the committee, I deeply appreciate being with you today. To begin with, I think it is wonderful what you have already done for children who are exceptional. You have brought two groups of people together, those in the services for exceptional children and those in vocational rehabilitation, to talk about problems.

We who work in the field of exceptional children, and I coordinate a program for all children and work for children who are exceptional, recognize that what we do for these children in the schools will be of little value unless they are rehabilitated and can find their equal place in society. So I think already you have contributed a great deal by bringing us together.

I want to say that my discussion today may be a little different. I am not pleading for a specific type of exceptionality. I am putting in a plea for all children who differ. As we think about children who are exceptional, regardless of what their exceptionality is, whether they are blind, whether they are visually impaired, or deaf, hard of hearing, have speech problems, whether they have problems of giftedness that have not been recognized and they do not have a program to meet them, no matter what it is, our end goal for these children is the same.

Our end goal is to see them as self-respecting citizens who have had an opportunity to develop to the maximum of their ability.

I feel that in your study, in the work that you are doing, we are making steps toward this. As we think about these children, we recognize that each type of exceptionality may attempt to reach that goal by a devious route, but it is our problem and our job to find out what that route is, to find out what blocks might be in their way, and to remove those blocks so that they might be able to eventually receive and be accepted as worthwhile and contributing citizens.

We think that through this study that you perhaps are doing the best thing that can be done, because you are working toward giving them these rights. You have heard statistics, I am sure, so today I want to talk a little bit about children. I want us to think about them for a few minutes. Let's think about what their needs are.

First of all, if we are talking about these children, they have to be identified. We have to know who they are, what their problems are, and what blocks are in their way.

Second, we have to know what treatments are available and if they can be treated in any way.

Third, we have to provide an educational program for them, so that they, too, can again receive their right education.

Fourth, we have to think about their needs for rehabilitation or habilitation, and finding a vocation, so that they can take their place.

I would like to first of all talk about these children in identification. We have heard today, you have heard, the need for qualified professional personnel. This is true if any of these needs are to be met and recognized. We have to have them in all fields, so I will not attempt to specify.

But I would like to talk to you about Mary, who was recommended for a class called mentally retarded, and whose teacher said that she was dumb and could not get anywhere. But upon adequate diagnosis, Mary was found to be superior, a gifted child.

I would like to tell you about Johnny, who was having a great deal of difficulty in school. He began stealing, he began having problems of various types, and it was found out after adequate diagnosis of Johnny that he had severe visual problems, that he had a problem at home that was unsolvable, but with proper education, work and planning, Johnny was able to take his place.

Frequently teachers, parents and others give names to children, like mentally retarded, dumb and mean, and because of this, frequently these children then may respond to those names and may eventually develop a concept that they are either mentally retarded or dumb and function that way.

So actually, we who work in the area of exceptional children feel that we must have adequate diagnosis to plan for these children. Only then, when they are available in public schools and in centers, can we adequately find them. Then, of course, after the child has been located and has been found, he needs medical care or clinical care of some type and treatment, and this needs to be provided.

An educational program to fit his needs must be provided, whether it is done in a residential school or in the public schools. But they need to have their needs and educational needs planned for and met.

If you have visited in some of the schools, you probably have seen 15-year-olds sitting in some first-grade classes or maybe some children who have not been allowed to go to school, as we have found in our State and in others. Perhaps because they are paralyzed from the waist down, or because they are too severely retarded, they think that they could not fit into a program.

We have calls for these all the time. Then as we are planning for these children, we need to recognize that the majority of our children's handicaps do not come singly, but they are multiple handicaps.

In a study that was done in Georgia on exceptional children, headed by Dr. Wishy, it was found that the total number of handicaps per child was approximately 2.7 per child. So as we plan for these children, then, we need to plan for children with multiple handicaps, because many of these children have varied means, because the child who is cerebral palsied may have a visual problem, a hearing problem, a speech problem; the child who is mentally retarded may have a speech problem.

If a child's needs are not being met, he may also develop another problem which becomes emotional, and that block will need to be removed before his needs can be adequately met.

So it is the feeling of the speaker that as we are planning and working for these children, we hope that your legislation as you consider and work with this will consider all areas of exceptionality. As was stated earlier, we would like to see any bills providing for

trainees, grants, and fellowships to include professional workers in all of the areas.

Some of our States have seen the wisdom of a broad legislative viewpoint by our foundation programs and by attempting to meet these needs as they are presented in both the local and in the States. It is our hope that legislation that is thought of will continue to do this as you are working with it.

It is also hoped, as was stated earlier, that children will be identified earlier and that programs will be planned for them earlier, educational programs. Many children miss the best years of their lives because they are identified too late or because a program is not provided for them soon enough.

Lastly, I would like to say that as we continue working, we are glad that you are willing to accept testimony and discussion from people in the field, and we hope that they, too, will have an opportunity of working on legislative platforms.

Thank you again for this opportunity.

Mr. ELLIOTT. Thank you, Dr. Jones, for your testimony. It was very fine.

We will now have a 5-minute recess and return at 4 o'clock.

(A short recess was taken.)

Mr. ELLIOTT. The subcommittee will come to order.

I want to thank Judge Graf Hart, the probate judge of this county, for furnishing us with coffee and refreshments. We appreciate that.

Also, I want to recognize Mayor C. R. Cain, of Oakman, Ala., and his friend and our friend, Joe M. Corry, from Oakman, Ala. We appreciate their presence.

Now I will recognize Dr. Merle E. Frampton, who has served and who is now serving as director of our workshop studies, which he has carried on in New York, New Haven, and Atlanta.

Dr. Frampton has brought from his workshop studies in Atlanta certain witnesses that he will tell us about. We will begin with them at this time.

STATEMENT OF DR. MERLE E. FRAMPTON, DIRECTOR, WORKSHOP STUDIES, SUBCOMMITTEE ON SPECIAL EDUCATION

Dr. FRAMPTON. Mr. Chairman and members of the subcommittee, this is the third of the regional workshops which the committee authorized your study staff to produce. This is the largest of all of the national workshops, encompassing 14 States and with something over 275 people in active participation yesterday.

I only want to say to you before introducing the consultant, the regional consultant, that the vast majority, about 99 percent of these people, came long distances at their own expense to give you the benefit of their thinking. They are all high-quality professional people in service, and some lay people.

At this time I am going to call upon Mr. William Geer, who is the associate director of the Southern Regional Educational Board, who has acted as the staff's regional consultant for the organization of this meeting. I am going to ask him to briefly explain the workshop to you and introduce the chairmen.

STATEMENT OF WILLIAM GEER, REGIONAL PROGRAMS ASSOCIATE,
SOUTHERN EDUCATION BOARD

Mr. GEER. Mr. Chairman and members of the committee, first of all I would like to correct the title that Dr. Frampton has promoted me to. I am regional programs associate for the Southern Education Board.

Secondly, I would like to say that today has been a somewhat nostalgic day for me. Not many people know, but I grew up in Alabama until the age of 23, somewhat north of here. I am an Alabama Yankee, from Bridgeport. I am very pleased to be here under more favorable conditions than formerly when the football team I used to support would come to Cullman and get the pants beat off of them.

We have had a very stimulating workshop in Atlanta for the last 2 days, and I think I bring from almost 90 percent, at least, of the people who are there, their thanks to this committee for calling such a meeting that they might come.

Dr. Frampton, they were pleased to pay their expenses. They had a very stimulating experience.

We hope that from this deliberation of 2 days ideas were recorded that will be presented to you that will help you to know what people of this region think is needed for the exceptional children and the handicapped and disabled adults of our region.

I realize that we cannot speak fully for the entire region, but may I say that the group of over 200 people is, I believe, representative of the various areas of handicapped. It is also a group of people dedicated to laying aside, at least as much as they could, their personal prejudices and ideas in attempting to join hands in a constructive discussion.

They were divided into seven groups and discussed visual disabilities, mentally retarded, speech and hearing problems, chronic disabilities, mentally and emotionally disturbed, neuromuscular and orthopedic disabilities, and the gifted.

Today we have seven spokesmen for those groups. You will understand that just about 4:30 yesterday they completed their deliberations. They have not yet had time to write up complete reports of their meetings. So at this time we would like to ask your permission to file complete reports from these seven committees later.

Mr. ELLIOTT. Without objection, the reports of the seven committees will be received within the next 15 days to 3 weeks and be incorporated into the record. Two or three weeks will give you time, will it not?

Mr. GEER. Yes. We are expecting them in 10 days.

Mr. ELLIOTT. You may proceed.

Mr. GEER. If it pleases the committee, then, I would like to present first to you as one of the cochairmen of the section on visual disabilities—the other chairman was Mr. Harry Simmons, executive director of the Florida Council for the Blind at Tampa—the cochairman representing education, Mr. J. M. Woolly, superintendent of the Arkansas School for the Blind at Little Rock. Mr. Woolly will present the report of that section.

STATEMENT OF J. M. WOOLLY, SUPERINTENDENT, ARKANSAS
SCHOOL FOR THE BLIND, LITTLE ROCK, ARK.

Mr. WOOLLY. Mr. Chairman, Mrs. Green, gentlemen of the committee, I represent, as Mr. Geer told you, Mr. Harry E. Simmons, the other cochairman, and some 50 people from across the 14-State region who are interested in people with visual disabilities. Obviously my time limit will keep me from giving you the total picture as we discussed it yesterday and the day before.

Some 35 areas of need were proposed and discussed. Of those 35, the group felt that 25, a full 25, needed action of some sort. So within our report we will have recommendations on these 25 areas. I want, however, to select those which seem to be of the most importance at this moment and call them to your attention now.

The first is within the area of special education. Under Public Law 531, 83d Congress, it is impossible for much needed research to be undertaken, since the law limits eligibility to colleges, universities, and State educational agencies. It is felt that there is an immediate need for much educational research, such as (a) types of psychological tests appropriate for blind and partially seeing children; (b) better methods of vision screening of children for admission to various educational programs; (c) the kind and size of large print most suitable for partially seeing children; (d) the efficient use of low vision aids for these children; (e) the development of orientation and travel techniques for blind children, particularly the very young.

The solution to this total problem, as recommended by the workshop, to provide for research in such areas, it is proposed that Public Law 531, 83d Congress, be expanded to include other appropriate agencies interested in and able to perform such educational research, if the research projects proposed meet the criteria for acceptability.

Secondly, a problem which took a great deal of time and discussion: The act to promote the education of the blind under present law has proven inadequate to meet the expanding needs for educational materials for blind children. The American Printing House for the Blind, which administers the act, has drawn up for presentation to the Congress certain proposals for amending the basic act with a view to alleviating the above situation.

The workshop heartily approves the following proposals for amending the act as proposed by the American Printing House for the Blind:

(a) The present ex officio trusteeship of the Printing House should be increased to include not only the administrative heads of public educational institutions for the blind, or their designees, but also the chief State school officers or their designees, representing the blind children attending public schools for the seeing, for purposes of the administration of the act only.

This would give equal representation on the Printing House Board of Trustees for public schools and State schools for the blind and would serve to bring to the Printing House the advice, counsel, and expression of need of all those responsible for the education of blind children insofar as the Federal act is concerned.

(b) There should be included in the language of the authorizing Federal act a provision for the establishment of advisory committees on publications, tangible apparatus, research and for such other purposes as may be deemed to be of help in administering the act, with proportionate representation between the residential schools for the blind and the children being educated in public schools. The provisions for such committees is now included in the bylaws only.

(c) There should be included in the authorizing legislation a definite statement to include ownership of materials now supplied under the act. At the present time, no such statement is included, nor has the Department of Health, Education, and Welfare been able to make a decision.

(d) A part of the annual appropriations not to exceed 10 percent should be set aside, apart from the provision of credit, for the purpose of paying salaries and other expenses of specialists and staffs to assist the publications and other such advisory committees in performance of their functions and for the expense of members of such committees, but not for the purpose of salaries of committee members.

These funds are noted so that the committee staff may have the help of experts throughout the country in determining materials to be provided and the manner in which they are to be provided. The Printing House, as a private agency, should not be expected to provide such counsel out of funds which it must obtain through charging other agencies a higher price for the materials they purchase through the facilities of the Printing House or through contributions from the general public.

(e) A sum of \$200,000 to \$300,000 should be appropriated outright to the Printing House in 1 year which it could use and then as a sort of revolving fund for capital outlay in the production of finished stock, so that it might be available for immediate delivery as needed on order from the educational institutions.

(f) The ceiling of limitations of the annual appropriation now set at \$400,000 should be eliminated entirely and such an appropriation should be requested and justified annually by the Printing House on the basis of the number of children to be served and costs of providing the materials needed.

Another problem that I would like to mention in the area of special education is that there are a growing number of visually handicapped children with other disabilities who can not be provided for in existing programs.

It is strongly recommended that the Congress take action to establish regional diagnostic treatment and training centers in order to meet the needs of these children. It is also recommended that provisions be made for the training of special personnel to staff these centers.

Now, within the area of rehabilitation, there are some special problems to which I would like to call your attention, the first one being that of the need to evaluate the services now being provided. Rather than read a rather lengthy statement, I want to read a portion of it, and then simply discuss it shortly.

It has been a matter of common knowledge that there is an astounding variance from State to State in the quality, quantity and extent of services made available to blind individuals. Some of the States offer a comprehensive program of services ranging from a residential

adjustment and rehabilitation center for the blind to postplacement counseling.

Other States offer only the most meager range of vocational services. This research is based on per capita expenditures in States, included in this study, and ranges from 2.4 cents per capita to 16 cents per capita. A list of State expenditures studied for this group of participating States and their per capita expenditures follow.

For obvious reasons, States are not identified except by code letters. As I said, in the statement itself the expenditures range from 2.4 cents per capita to 16 cents per capita, within the 16 Southern States which were included within this study, a wide divergence of service, indeed.

It is very significant to note that the national average per capita expenditure for public assistance is 49 cents.

A study should be conducted to establish a parity figure which would be the average of the higher half of all the States offering services to blind persons and (b) preparation of legislation and/or amendments to the provisions of Public Law 565 to make available for a specified number of years Federal funds permitting the low States to reach a parity per capita expenditure with the understanding that the States would make available at the conclusion of the period sufficient funds to meet matching requirements of funds in Public Law 565.

The need for Federal participation in research and in causes and prevention of eye diseases: Statistics indicate an increase. Obviously, with the increase in overall population, the incidence of blindness is increasing. Suggestions of solution would be considering the bulk of Federal-State funds absorbed in (a) underwriting financial assistance to persons unable of self-support; (b) education of the blind; (c) medical eye care; and (d) vocational rehabilitation.

It is strongly urged that support be given to legislation providing additional funds and more dynamic implementation of existing private and Federal and medical-socio programs devoted to the prevention of related eye disease.

One other problem: The need for clear-cut definition of various levels of visual impairment which constitutes avocational and/or vocational handicap. The present accepted definition of blindness creates confusion in the public mind. However, until such time as a thoroughgoing study can be undertaken, it is necessary that all Federal legislation pertaining to the blind conform to the commonly accepted definition of 20/200 or less in the better eye, and so on.

Suggested solution: A study to develop and to standardize definitions on a national level of visual impairments which constitute avocational and/or vocational handicapped, including persons with vision greater than 20/200.

I am sorry I have consumed slightly more than my time.

WORKSHOP REPORT ON THE VISUALLY IMPAIRED

It is with a great deal of satisfaction that the cochairman makes a report of the Workshop on the Rehabilitation of the Visually Handicapped to the Subcommittee on Special Education of the Committee on Education and Labor of the U.S. House of Representatives.

The workshop was fortunate in attracting a large representative group of 43 experienced and interested people in the field of services for the blind from the

large number of States included in this study. Prior to the workshop meeting, the cochairman for the group received from many of the participants notations regarding clearly identified troublesome areas and proposed solutions to some of the problems posed.

During the progress of the workshop, realistic and objective consideration was given to each area of service inadequacy and there was a free interchange of ideas. Minority opinions were given careful and courteous consideration in all of the discussions. It was recognized that the blind individual traditionally has been at a serious disadvantage in functioning to the levels of his abilities within the framework of the socioeconomic institutions of a sighted society. Much progress has been made in expanding the possibilities for a more normal life for those who are blind, but much more needs to be done. However, it was evident that there was lack of sufficient time to consider the breadth of the subject matter assigned to this workshop; and it was unanimously recommended that a vehicle for additional workshop meetings should be provided for in the future.

The following is a list of most pressing inadequate service areas for the visually handicapped with proposed solutions representing the majority opinion of the group. Attached is a list of the workshop group who participated in the study of the rehabilitation of the visually impaired.

Inadequate service area No. 1.—Needs of multiple unemployable handicapped blind persons.

Blindness as an employment handicap is often aggravated by one or more coexisting disabilities which renders effective or full-time employment impossible. The group thus affected certainly constitute a significant number of blind persons. This group then is wholly confined to existence by public assistance, and such subsistence is certainly not conducive to high morale, satisfaction, and happiness. Many of this group could improve their condition by part-time non-competitive or homebound employment which would have important psychosocial as well as economic benefits.

Suggested solution: Title X of the Social Security Act should be amended to provide the exclusion of a total of \$1,200 net income per annum regardless of source in computing the financial resources of blind recipients of public assistance moneys or grants.

Inadequate service area No. 2.—Needs of blind persons able to pursue limited or full employment.

Certain legal restrictions exist that act as a deterrent to the seeking of partial or full employment of blind persons. These restrictions relate to the very limited amount of earned income that can be excluded in the determination of economic need for public assistance and the restrictive limits in savings or equity which may be accrued in a newly established business venture.

Suggested solution: It is therefor recommended that the above restrictions be modified so that an employable blind person can rise above bare subsistence level of living by amending title X of the Social Security Act to permit—

(a) That one-half of the earned income of blind recipients of public assistance be excluded in arriving at their total financial resources, up to a maximum of \$2,400.

(b) That the value of their permanent home be disregarded as a resource.

(c) That the face value of life insurance policies, up to a total of \$5,000, be waived in the computation of financial resources.

(d) Additional resources of blind recipients in the form of real or personal property, or income, which are deemed necessary and intended to activate vocational plans for achieving self-support be retained by recipients.

(e) For the purpose of encouraging and enabling a greater number of recipients of aid to the blind to become self-supporting, all expenditures incurred by a recipient in effecting his plan to become self-supporting, including payments made for the purchase of fixtures and material needed by him in effecting such plan, shall be deducted from gross income in computing net income, provided that such payments shall not be more than \$100 per month.

Inadequate service area No. 3.—Need to evaluate the services provided.

It has long been a matter of common knowledge that there is an astounding variance from State to State in the quality, quantity and extent of services made available to blind individuals. Some of the States offer a comprehensive program of services ranging from a residential adjustment and rehabilitation center for the blind to post placement counseling. Other States offer only the most meager range of vocational services. The research is based on per capita expenditures in States included in this study and range from 0.024 to 0.160 per

capita. A list of State expenditures studied for this group of participating States and their per capita expenditures are as follows (for obvious reasons, States are not identified except by code letter) :

State	Expenditures, fiscal 1959	Per capita
a.....	\$75,058.00	0.024
b.....	67,174.00	.028
c.....	108,044.00	.030
d.....		.033
e.....	149,000.00	.046
f.....	426,473.00	.046
g.....	180,590.00	.047
h.....	182,634.00	.058
i.....	63,242.00	.076
j.....	164,265.68	.094
k.....	386,795.00	.110
l.....	600,677.00	.130
m.....	637,368.00	.140
n.....	363,971.00	.160

It is very significant to note that the national average per capita expenditure for public assistance is 0.49-AB.

Suggested solution: (a) Study should be conducted to establish a parity figure which should be the average of the higher half of all the States offering services to blind persons.

(b) Preparation of legislation and/or amendments to the provisions of Public Law 565 to make available, for a specified number of years, Federal funds permitting the low States to reach a parity per capita expenditure with the understanding that the individual States would make available, on the conclusion of the period, sufficient funds to meet matching requirements of Public Law 565.

Inadequate service area No. 4.—Need for comprehensive insurance programs for visually handicapped persons.

Certain inequities in insurance rates and coverage which appear to exist for individuals and groups of blind persons are such that a study of this area is indicated to encourage action to correct seemingly discriminatory rates.

Suggested solution: That a study be made to determine means of meeting insurance needs of blind people adequately.

Inadequate service area No. 5.—Need for increase in Federal financial participation in public assistance programs for the blind in order to increase the dollar amount received per month.

The basic needs of blind persons are the same as those of every other individual but in addition there are needs peculiar to the handicap of blindness principally because the blind individual is so often cut off from resources available to the sighted world. The current \$65 per month ceiling on Federal participation depresses the standard of living of blind recipients to bare existence. Such a condition can be corrected only by increasing the ceiling on Federal participation in the program.

It is apparent that the total increased costs that will be entailed in desired improvements in public assistance for the blind cannot, at least initially, be completely borne by the States.

Suggested solution: Legislation should be prepared to amend title X of the Social Security Act to provide a change of formula from the present average of \$65 per month to an increased amount more realistically based on the cost of living.

There was considerable difference of opinion on this question; the final vote was 11 for and 7 against approval.

Inadequate service area No. 6.—Need for better understanding of the needs of blind recipients of public assistance and rehabilitation clients.

Administrators of public assistance and rehabilitation who are unable to devote an adequate portion of their time and energies to the analysis of the special needs of blind persons sometime fail to understand the difference in the unique conditions which affect blind recipients and those which prevail for recipients of other public assistance categories who are not blind, and which to a great extent form the basis upon which public assistance and rehabilitation programs are developed and administered. If this situation is to be corrected there must be a differentiation of public assistance for the blind from the other categories.

Suggested solution: (a) That each State agency administering or supervising the administration of aid to the blind and/or rehabilitation should create a bureau or division for the blind devoted to carrying out the administration of aid to the blind and/or rehabilitation services. This is the only truly effective means of assuring a reasonably adequate solution to the problem as stated;

(b) That title X of the Social Security Act should be amended to provide at least one full-time consultant on services to the blind in the public assistance office of the U.S. Department of Health, Education and Welfare;

(c) That the Bureau of Public Assistance should regularly collect and more widely distribute statistics on recipients of aid to the blind.

Inadequate service area No. 7.—Need for amendments to Public Law 565 affecting rehabilitation clients including small business enterprises.

Present provisions of Public Law 565 have demonstrated certain weaknesses with respect to the following:

1. The inability of State agencies to pay rent and utilities for more than a period of 1 month.

2. The inability of State agencies to pay for the renting of operational equipment for more than a period of 4 months.

3. The inability to provide maintenance following the placement of the client beyond his first pay check or 1 month.

These limitations in many instances jeopardize the vocational rehabilitation of blind persons.

Suggested solution: Public Law 565 be amended to authorize an agency to pay operational expenses for blind rehabilitation clients when necessary including clients placed in small business enterprises program for a period not to exceed 1 year, and to provide for the payment of maintenance for a period not to exceed 1 year following the initiation of the business enterprise.

Inadequate service area No. 8.—Need for amendment of Public Law 565 concerning the provision of reader service to blind persons in training.

The economic needs requirement for reader service imposed by Public Law 565 has worked a great hardship on blind persons attending schools and universities.

Suggested solution: Public Law 565 and its attendant regulations should be amended so that the provision of reader service to blind clients in training would not be subject to a determination of financial need.

Inadequate service area No. 9.—Vending stands and/or snack bars.

The passage of Public Law 732 (Randolph-Sheppard Act) as amended has provided many lucrative employment opportunities for blind persons. However, in recent years, there has been a steady increase in the installation of vending machines by groups other than blind persons in Federal buildings or properties where vending stands are or might feasibly be operated by blind individuals.

Suggested solution: (a) Public Law 732 should be amended to prevent the income from vending machines accruing to any groups other than blind stand operators in Federal buildings or on Federal property where vending stands and/or snack bars may be profitably and satisfactorily operated by blind persons, or where, at the discretion of the State designated licensing agency, vending stands have been or should be permitted.

(b) Likewise, in architectural plans for future Federal buildings, provisions should be made for a suitable location for a vending facility. This provision should apply to buildings being erected under the lease-purchase act and, as far as feasible, in federally financed hospitals.

Inadequate service area No. 10.—Need for increased Federal participation in research in causes and prevention of eye diseases.

Statistics reveal a marked increase in blindness resulting from a variety of causes. Obviously with the increase in overall population the incidence of blindness is proportionately increasing. The great increase in the number of aged in the United States has materially affected this factor.

Suggested solution: Considering the bulk of Federal-State funds absorbed in (a) underwriting financial assistance of persons incapable of self-support because of disabilities related to blindness; (b) education of the blind; (c) medical eye care; and (d) vocational rehabilitation, it is strongly urged that support be given to legislation providing additional funds and more dynamic implementation of existing Federal and private medical and medical-social research programs devoted to prevention of related eye disease.

Inadequate service area No. 11.—Need for an independent living program.

Pressing and important unmet needs are further accentuating the lack of Federal-State responsibility (legislation) in providing services to blind persons incapable of productive and competitive employment and dependent upon daily home care needs and/or ultimate institutional care. Undoubtedly, a large proportion of this group are capable of training in self-care and increased daily activities, useful and independent living, and others are capable of absorbing training in home or restricted productive activity of a noncompetitive nature.

Suggested solution: Support of amendment to Public Law 565 in providing the necessary legislation, extending services to that group not now eligible for vocational rehabilitation but capable of benefiting from rehabilitation services assisting in greater independent usefulness, personal efficiency and possible limited employment. Also, provide for sufficient personnel, diagnostic facilities and rehabilitation centers needed in activating such a program. Federal funds will need to be provided for the training and employment of professional personnel to accomplish these aims.

Inadequate service area No. 12.—Need for additional Federal support to finance training of personnel as specialists in all areas of work for the blind.

There is an increasing need for training additional personnel in the special procedures in all areas of resources for blind individuals.

Suggested solution: That an increase in funds through Public Law 565 should provide an increase in the amount of the financial assistance and in the number of scholarships and fellowships so that these professional and technical specialists may receive special training and orientation in serving blind persons. Also grants be provided to public and private agencies providing competent rehabilitation services so that they can employ qualified personnel to supervise internships of special graduate students in the field of services to the blind and visually handicapped.

Inadequate service area No. 13.—Visually handicapped not being served by any group.

There are a large number of individuals whose vision is greater than 20/200 but who have an impairment which constitutes a severe vocational handicap who are in a twilight zone as far as being eligible for service. Apparently they are not receiving adequate services to meet their needs.

Suggested solution: It is therefore strongly urged that the subcommittee through appropriate amendments to existing legislation take cognizance of this need and make ample provision so that these visually impaired persons will receive those vocational rehabilitation services which will develop their maximum employment potential.

Inadequate service area No. 14.—Need for clear-cut definition of various levels of visual impairment which constitutes a vocational and/or educational handicap.

The presently accepted definition of blindness creates confusion in the public mind. However, until such time as a thoroughgoing study can be undertaken, it is necessary that all Federal legislation concerning the blind conform to the commonly accepted definition quoted below:

“Central visual acuity of 20/200 or less in the better eye, with corrective glasses, or central visual acuity or more than 20/200 if there is a field defect in which the peripheral field has contracted to such an extent that the widest diameter of visual field subtends an angular distance no greater than 20° in the better eye.”

Suggested solution: Study to develop and to standardize definitions on a national level of visual impairment which constitute a vocational and/or educational handicap, including persons with vision greater than 20/200.

Inadequate service area No. 15.—Diffused approach to the many problems concerning services for the visually handicapped.

The group was greatly concerned that the workshop seemed to be following the traditional pattern for developing legislation. Heretofore, there has been a great preponderance of proposed legislation with little regard for long-term planning. It was obvious that time limitations were militating against the group in the development of a thorough coordinated legislative program incorporating the philosophy, principles, and standards which should be inherent in any major changes suggested by the workshop participants to the subcommittee.

Suggested solution: Additional workshops where further exploration of basic philosophies in relation to long-term planning should be considered. Workshops of this nature should provide for sufficient time to discuss standards, philosophies and principles for guidance in future legislation.

The workshop group thought it would be of interest to list those inadequate service areas which time did not permit discussing but which had been listed for the agenda:

1. Need for a department or division of services for the blind in each regional OVR office to provide qualified experienced persons whose primary responsibility should be consultation on providing constructive services to the blind.
2. Need for revision of U.S. civil service laws to prevent discrimination against blind persons, coupled with specialists for the blind to acquaint appointing officers with the capabilities of blind applicants.
3. Need for establishing comprehensive diagnostic and evaluation centers for the blind, including those with multiple disabilities.
4. Need for research on how blind persons function on the job.
5. Need for standards for training programs for mobility orientors.
6. Need for the proposed disability freeze.

ADDITIONAL REPORT ON THE VISUALLY IMPAIRED

Problem 1.—There is a critical need throughout the Nation, particularly in the southern region, for trained qualified teachers of visually disabled children, as well as ancillary personnel, such as counselors and therapists. Some of the major reasons for this situation are—

- (a) Attraction of better teaching salaries outside of the region.
- (b) Attraction of better salaries and fringe benefits in industry.
- (c) General shortage of qualified teaching personnel.
- (d) Shortage of training centers within easy geographical reach of teachers and prospective teachers.
- (e) Lack of funds for the financing of study leave.

Solution: The provision of Federal grants-in-aid, or the establishment of scholarship funds, through the appropriate Federal department, looking to the training of teaching and ancillary personnel for the education of the visually disabled. This should include teaching personnel at the college level, as well as below.

Problem 2.—Experience dictates that, when attempts are made to meet the problems of special education through omnibus legislation, the needs of the visually disabled as well as others, sometimes suffer. This is particularly true in the area of the severely disabled, since this group comprises less than 1 percent of the total known group of exceptional children.

Solution: It is recommended that such Federal assistance as may be provided through the Congress shall at all times be made available on a categorical basis to children with visual disabilities, as well as visually handicapped children with additional disabilities (the multihandicapped).

Problem 3.—Aside from direct service needs of blind children, it was felt in some quarters that there is an added expense to parents of blind children for educational activities.

Solution: It is proposed that the Internal Revenue Code be amended to provide an extra exemption of \$600 per blind child per year for parents of blind children.

(NOTE.—This proposal was defeated 12 to 11, with a number abstaining.)

Problem 4.—Under Public Law 531, 83d Congress, it is impossible for much needed research to be undertaken, since the law limits eligibility to colleges, universities, and State educational research, such as—

- (a) Types of psychological tests appropriate for blind and partially seeing children.
- (b) Better methods of vision screening of children for admission to various educational programs.
- (c) The kind and size of large print most suitable for partially seeing children.
- (d) Efficient use of low-vision aids.
- (e) The development of orientation and travel techniques for blind children, particularly the very young.

Solution: To provide for research in such areas, it is proposed that Public Law 531, 83d Congress, be expanded to include other appropriate agencies interested in and able to perform such educational research, if the research projects proposed, meet the criteria for acceptability.

Problem 5.—There is a need to locate and identify visually disabled children at the earliest possible age, and to provide appropriate services to them and their parents.

Solution: A strong program of casefinding and parent counseling should be set up through—

(a) Federal Government assistance to the State and private facilities for setting up standards for casefinding and parent counseling.

(b) Grants-in-aid now being provided for training personnel being extended to include workers in this area.

Problem 6.—The act to promote the education of the blind under present law, has proved inadequate to meeting the expanding needs for educational materials for blind children. The American Printing House for the Blind (which administers the act) has drawn up for presentation to the Congress certain proposals for amending the basic act with a view to alleviating the above situation.

Solution: The workshop heartily approves the following proposals for amending the act as proposed by the American Printing House for the Blind:

(a) The present ex officio trusteeship of the Printing House should be increased to include, not only the administrative heads of public educational institutions for the blind (or their designees), but also the chief State school officers (or their designees), representing the blind children attending public schools for the seeing—for purposes of administration of the act, only. This would give equal representation on the Printing House board of trustees for both the public schools and the residential schools for the blind, and would serve to bring to the Printing House the advice, counsel and expression of need of all those responsible for the education of blind children, insofar as the Federal act is concerned.

(b) There should be included in the language of the authorizing Federal act a provision for the establishment of advisory committees on publications, tangible apparatus, research, and for such other purposes as may be deemed to be of help in administering the act, with proportionate representation between the residential schools for the blind and the representatives of children being educated in public schools. The provisions for such committees is now included in the bylaws of the Printing House only.

(c) There should be included in the authorizing legislation a definite statement to indicate ownership of materials supplied under the act. At the present time, no such statement is included, nor has the Department of Health, Education, and Welfare been able to make a definite decision on this point.

(d) A part of the annual appropriation, not to exceed 10 percent, should be set aside, apart from the distribution of credit for the provision of books and apparatus to the schools and classes, for the purpose of paying salaries and other expenses of experts and staff to assist the publications and other such advisory committees in performance of their functions, and for expenses of members of such committees, but not for the purpose of salaries for committee members. These funds are needed, so that the Printing House staff may have the benefit of the help of experts and people responsible for the education of blind children throughout the country in determining materials to be provided and the manner in which they are to be provided. The Printing House, as a private agency, should not be expected to provide such counsel out of funds which it must obtain through charging other agencies a higher price for the materials they purchase through the facilities of the Printing House or through contributions from the general public.

(e) A sum of \$200,000 to \$300,000 should be appropriated outright to the Printing House in 1 year, which it could use from then on as a sort of revolving fund for capital outlay in the production of finished stock, so that it might be available for immediate delivery as needed on order from educational institutions. As it now stands, the Printing House is hard pressed for current cash, because of its attempts to keep known items of fairly constant demand in stock in anticipation of orders from schools and classes, and a very real hardship is being worked on the institution because of its desire to provide services out of its own funds, for which it has not only any assurance of repayment, but which is not its responsibility, based on the present Federal act.

(f) The ceiling of limitation of the annual appropriation, now set at \$400,000 should be eliminated entirely, and such appropriation should be requested and justified annually by the Printing House on the basis of the number of children to be served, and costs of providing the materials needed.

Problem 7.—There is a lack of any legislation to provide educational materials and equipment for identifiable partially seeing children. The criticalness of this situation is emphasized by the existence of a large number of such children in need of these materials.

Solution: To meet the problems imposed on special education by the large numbers of partially seeing children, it is proposed—

(a) That The Department of Health, Education, and Welfare be authorized to institute a study and develop a long-range program covering this area.

(b) Because of the dire emergency now existing, due to the lack of materials for instructional purposes for partially seeing children, a crash program be initiated consisting of immediately available funds for the preparation and purchase of such materials.

Problem 8.—Educationally related materials, as provided by the Division for the Blind of the Library of Congress through its talking book program, are somewhat limited, both in scope and quantity.

Solution: The Library of Congress should be urged to request additional necessary funds with which to make available a wider variety and an increased number of educationally related materials of this kind.

Problem 9.—In most Southern States, it appears that many children are in need of and are eligible for remedial eye-medical services which cannot be provided due to present Children's Bureau regulations.

Solution: (a) It is urged that the Children's Bureau revise its regulations so that any State agency for the blind, or other State agencies which can provide such services, be made eligible to receive such funds.

(b) It is further recommended that Congress be requested to increase the appropriation to the Children's Bureau for crippled children's services to implement recommendation (a).

Problem 10.—There is a growing number of visually handicapped children with other disabilities who cannot be provided for in existing programs.

Solution: (a) It is strongly recommended that Congress take action to establish regional diagnostic, treatment, and training centers, in order to meet the needs of these children.

(b) It is also recommended that provisions be made for the training of special personnel to staff these centers, as well as itinerant consultants.

WORKSHOP PARTICIPANTS

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J. M. Woolly, cochairman, Arkansas

Alabama

Miss Mary Ann Bostick, Birmingham, Ala., Woodlawn School.

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Arkansas

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Mr. Roy Kumpe, Little Rock, Ark., managing director, Arkansas Enterprises for the Blind, Inc.

Florida

Mr. J. M. Wallace, St. Augustine, Fla., president, Florida School for Deaf and Blind.

Mr. Lee Iverson, St. Augustine, Fla., principal, Florida School for Deaf and Blind.

Mr. Robert L. Robinson, Orlando, Fla., field representative, Blinded Veterans Association.

Mr. Maurice I. Tynan, Tangerine, Fla., chairman, Blind Advisory Committee of Florida.

Mr. G. J. Emanuele, Tampa, Fla., director, medical and social service, Florida Council for Blind.

Mr. Harry Simmons, Tampa, Fla., director, Florida Council for the Blind.

Georgia

Mr. Louis R. Schubert, Atlanta, Ga., regional representative, region IV, Office of Vocational Rehabilitation.

Dr. Mamie Jo Jones, Atlanta, Ga., coordinator, services for exceptional children, State department of education.

Mr. W. B. Gaines, Atlanta, Ga., president, National Council of State Agencies for the Blind.

Mr. Arthur Lown, Atlanta, Ga., director, program for exceptional children, Atlanta City Board of Education.

Miss Aurelia Davis, Atlanta, Ga., director, program for exceptional children, Atlanta City Board of Education.

Kentucky

Miss Marjorie Hooper, Louisville, Ky., Braille and large-type editor, American Printing House for the Blind.

Mr. L. P. Howser, Louisville, Ky., superintendent, Kentucky School for the Blind.

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Mr. James Perry, Baton Rouge, La., Louisiana State Department of Education.

Mr. W. C. Gill, Baton Rouge, La., superintendent, Louisiana State School for the Blind.

Mississippi

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Mr. John W. Eakes, Jackson, Miss., superintendent, Mississippi School for the Blind.

New York

Mrs. Doris Sausser, New York, N.Y., field representative, division of community services, American Foundation for the Blind.

North Carolina

Mr. H. A. Wood, Raleigh, N.C., executive director, North Carolina Commission for the Blind.

Oklahoma

South Carolina

Mr. John Zuidema, Columbia, S.C., South Carolina State Board of Education.

Mr. J. M. Cherry, Columbia, S.C., chief, division for blind.

Mr. Marshall Tucker, Columbia, S.C., South Carolina Aurora Club, Inc.

Tennessee

Mrs. Amie Denison, Nashville, Tenn., resource teacher, Howard School.

Mr. E. J. Wood, Nashville, Tenn., superintendent, Tennessee School for the Blind.

Mr. William Ferrell, Nashville, Tenn., supervisor, rehabilitation for blind, State department of public welfare.

Mr. Sam Ashcraft, Nashville, Tenn., professor, George Peabody College.

Texas

Mr. Lon Alsup, Austin, Tex., executive secretary-director, State commission for blind.

Mr. R. Doyle Best, Dallas, Tex., Office of Vocational Rehabilitation, regional representative, region VII.

Mrs. Irene Westmoreland, Houston, Tex., consultant, division of special education, department of education.

Mrs. G. Rougagnac, Houston, Tex., executive director, Houston-Harris City Lighthouse for the Blind.

Virginia

Mr. Robert W. McDonald, Alexandria, Va., president, Virginia Federation for Blind.

Mr. Joseph Shinpaugh, Staunton, Va., superintendent, Virginia School for Deaf and Blind.

Dr. D. C. MacFarland, Richmond, Va., executive secretary, Virginia Commission for the Blind.

West Virginia

Mr. ELLIOTT. Thank you very much.

Before we go on with our next witness, let me acknowledge the presence of Mr. Raymond Faught, the county superintendent of education of Walker County, our adjoining county; Dr. Jesse Burbadge, of the city school system, and Mr. Buel Cobb, the chairman of the city board of education of this city; Sheriff Crant Waldrop, who has been very helpful to the members of the subcommittee in getting the arrangements made for the subcommittee.

To all of you we express our appreciation.

Mr. Geer?

Mr. GEER. The cochairman of the section on the mentally retarded were Miss Grace M. Smith, assistant supervisor of special education service, State department of education, Richmond, Va., and Mr. Louie O. Sluder, director of Career and Guidance, Inc., 1300 San Antonio Street, Austin, Tex.

I might say that Mr. Sluder's organization is devoted to the rehabilitation of mentally handicapped youth and is performing quite a good service. Mr. Sluder will be the spokesman for his section.

STATEMENT OF LOUIE O. SLUDER, DIRECTOR, CAREER AND GUIDANCE, INC., AUSTIN, TEX.

Mr. SLUDER. Mr. Chairman and members of the committee, I am speaking to you in behalf of the workshop committee on mental retardation. The first thing I would like to say is that our entire group of professional people who came from all over this region were literally effervescing with enthusiasm and appreciation for this opportunity. We wanted to go on record that we feel you have already made a greater contribution than what you might know or realize in the future, just by bringing us together.

Our committee worked together compatibly, congenially, and provocatively. We think this was one of the most interesting quests as to what the urgent needs of the mentally retarded we have ever experienced. Here again we perhaps will hear a lot about Federal duplication, but I will not seek to duplicate too much.

I would bring to you the high points and we will submit our full report as you have requested.

The first urgent need we feel is a comprehensive, evaluative and diagnostic center. The stress here is for all handicapped, not simply the mentally retarded. But this diagnostic center would be adequately staffed to give certified or valid diagnosis of the child's medical, psychological, and social-vocational assessments.

Such centers should be strategically located and available to children in need of such services. This type of facility should assist in the early identification of the mentally retarded child, the counseling of the parents of the retarded child, the promotion of preparation during the child's preschool years for meeting those critical influences which reflect the individual's total social, intellectual, and personality development; the periodic reevaluation and further followup of the

child. This facility would be administered as the States see the needs.

Federal grants are needed in those geographical areas where no facilities are now in existence, and then further extensions for those areas where there are some facilities.

For example, in Alabama they made a request of some \$200,000 the first year, \$300,000 the second year, and \$400,000 the third year to set up these diagnostic centers. George Jarre requested two centers. Oklahoma wanted \$250,000 simply to start the program, and Texas, 10 centers.

May I say here that we did not seek to put an orbit around the moon. We wanted simply to get started in this program. We do not have it all worked out in a very utopian manner. We just want some assistance to get on the ground floor and get started.

The second urgent need is training for professional and nonprofessional personnel that present scholarships and grants-in-aid provisions now confined to graduate programs be expanded to provide scholarship aids to students in the undergraduate level in the junior and senior years and to colleges offering approved programs on the graduate degree level in special education. Adequate training programs should be established on a regional basis.

The third urgent need is for further coordination of services between special education and rehabilitation which could or should be effected at the Federal level; the removal of restrictions which presently prohibit special education, vocational education, and vocational rehabilitation from working together for the best education, training and work opportunity possible for all mentally retarded.

For example, the removal of barriers such as employable age, number of hours or formalized training necessary, et cetera. The stress here is for maintenance of supervision for the mentally retarded in order to work with them as long as the need is indicated.

The fourth urgent need is research, joint research by vocational rehabilitation and special education on what the curriculum content should be for the mentally retarded child in order to prepare them for employment.

The fifth urgent need is for workshops. We are asking that there be extended threefold, at least, the moneys available for workshops. Such funds should be liberalized for those areas which are unable to meet the cost of matching funds.

The last need that I bring to you is a residential care for mentally retarded during the period of training. Residential care should be provided for some mentally retarded persons during the period necessary for evaluation and training. This may take the form of the halfway house or other residential facilities, where children may live under a supervised environment during the process of training and employment.

I thank you, and I appreciate this opportunity to appear.

WORKSHOP REPORT ON MENTALLY RETARDED

Cochairmen

Special education: Grace Maynard Smith special education service, State Department of Education, Richmond, Va.

Rehabilitation: Louie O. Sluder, director, Career & Guidance, Inc., Austin, Tex.

Participants

Almand, W. Fortson, director, C-Barc Occupational Center, Shreveport, La.
 Armstrong, Floyd H., State supervisor, Vocational Rehabilitation Service, State Department of Education, Richmond, Va.

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Elser, Roger P., State director special education, State Capitol, Charleston, W. Va.

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Spicker, Harold H., candidate, Peabody College, Special Education Department, Nashville, Tenn.

Stewart, George (Mrs.), executive secretary, Georgia Association for Retarded Children, Atlanta, Ga.

Tait, Elizabeth, principal, Russell School, Mobile, Ala.

I. A REVIEW OF EXISTING LEGISLATION AND SERVICES

Conclusions: Most of the various functional and operational services now offered in the area of mental retardation have value and have served to a limited degree the purpose for which they were originally organized and established. Population growth, increased understanding and public acceptance of mental retardation, along with increased operational costs, give rise to constant expanding needs in the field.

II. THE MOST URGENT UNMET NEEDS IN THE AREA OF MENTAL RETARDATION

1. Resources for the proper and complete identification of mentally retarded children.

2. Resources for training professional and nonprofessional personnel.

3. Further coordination of services between special education and rehabilitation for more effective training and personal rehabilitation.

4. Research, both basic and applied.

5. Facilities for training the mentally retarded in supervised environments.

III. RECOMMENDATIONS FOR LEGISLATION WHICH WILL AID IN THE SOLUTION OF EXISTING PROBLEMS AND UNMET NEEDS

A. Comprehensive evaluative and diagnostic clinics or centers for all handicapped, including the mentally retarded. These should be adequately staffed to give certified or valid diagnosis of the child's medical, psychological, and social-vocational assessments. These centers should be strategically located in various geographical areas and made available to all children in need of such services. This type of facility should assist in—

1. The early identification of mentally retarded children.
2. The counseling of parents of retarded children.
3. The promotion of preparations during the child's preschool years for meeting those critical influences which reflect in the individual's total social, educational, and personality development.
4. The periodic reevaluation and further followup of children when needed.

This facility would not be needed by all handicapped children but rather by those who have no other resources for valid identification.

Federal grants are needed for those geographical areas where no facilities of this kind are now existent, and for extension of services now in existence for an estimated 700,000 youngsters in the United States—some preschool age, and others older—who need this service.

Evaluative and diagnostic services should be provided through mobile units in certain of the more obscure areas.

The above facilities would be administered as the States see the need.

B. Training for professional and nonprofessional personnel

Present Federal scholarships and grants-in-aid provisions, now confined to graduate programs, be expanded in order to provide scholarships and grants-in-aid to students on the undergraduate level in the junior and senior college years. If not direct grants, then grants on a loan basis to undergraduate students would provide potentials for training more classroom teachers.

Present Federal scholarships and grants-in-aid be continued to those colleges and universities offering approved programs on the graduate degree level in special education.

Training programs, for economy purposes, should be established on regional basis. That is, one college or university should be designated as the center for complete training for the blind, another should emphasize training for the emotionally disturbed, according to the existing facilities or potentials for a training center.

Adequate stipends for training should be made available to—

Teachers for the mentally retarded (those preparing to teach and those already teaching).

Persons serving in supervisory positions in the field of mental retardation.

Counselors for parents of mentally retarded children.

Psychologists (services needed for valid identification of the mentally retarded).

Administrative personnel (particularly those employed in institutions, workshops, and centers for the retarded).

Persons in need of inservice training for nonprofessional positions in the field of retardation.

Federal grants for traineeships should be made on the bases of requirements for certification and training, with consideration as to the time and individual effort necessary to complete the required study. Some grants might be offered on an annual basis; others for a longer period. Some should be allocated for summer study, for personnel already in service who wish to prepare themselves for more effective leadership.

The sum of \$500 per quarter is considered a reasonable scholarship grant for those working at a graduate level leading to a doctorate degree. Special arrangements should be made for dependents.

Adequate training should include certain prescribed courses along with professional proficiency in the respective fields, as well as the ability to work with others.

Federal funds should be made available for professional workshops where leaders may meet in regional groups to study needs and to provide suggested ways of meeting such needs in the field of mental retardation. Workshop participants should include psychologists, social workers, guidance directors, teach-

ers, administrators, supervisors, parents, vocational rehabilitation workers, and others concerned with mental retardation.

C. Further coordination of services between special education and rehabilitation which could or should be effected at the Federal level

Legislation should be considered for the removal of restrictions which presently prohibit special education, vocational education, and vocational rehabilitation from working together for the best education, training, and work opportunities possible for all mentally retarded children. The removal of barriers such as employable age, the number of hours of formalized training required, and other similar limiting regulations, would make for better cooperative effort and more effective rehabilitation of mentally retarded youth for training and employability.

Legislation affecting the training and rehabilitation of mentally retarded youth should stress the "maintenance of supervision" for them as long as the need is indicated.

D. Research

Efforts should be continued and extended to encourage research in the field of mental retardation. There is need for both basic and applied research, in order to add to our present knowledge and to assist in the evaluation of certain techniques and procedures now in use.

The gap between basic and applied research could be "filled in" considerably by setting up research centers with persons in leadership positions capable of directing research and giving practical help to those in the field.

Joint research is needed by vocational rehabilitation and special education to determine the nature of the curriculum content for mentally retarded children, in order to prepare retardates for more satisfying living and employability. Such research should include findings concerning:

Social attributes.

Essential academic skills.

General understandings concerning the world about them.

Skills (manual and otherwise) that will transfer from school experiences to employment situations.

Special education and vocational rehabilitation in each State could undertake to work on curriculum studies for mentally retarded, without additional expense to the Federal Government. The findings should be gathered, compiled, and distributed by the Federal Government.

E. Workshops

Sheltered workshops, particularly for the mentally retarded in the classification of the trainable, are needed in all geographical areas. There should be a threefold extension of funds now available for the development of sheltered workshops. These workshops should be set up with facilities for training and terminable placement of mentally retarded individuals.

Funds for workshops should be liberalized for those areas which are unable to meet the cost of matching funds.

Moneys should be made available for homebound employment of the mentally retarded who cannot, for various reasons, attend the area workshops.

F. Residential care for the mentally retarded during period of training

There are certain individuals in the classification of the mentally retarded who cannot be successfully trained in their local environment. Residential care should be provided for those mentally retarded persons who must be removed from their homes for a period necessary for their evaluation and training. This facility may take the form of Half-Way Houses or other residential facilities where children may live under a supervised environment during the process of training and employment.

The number of such facilities would depend upon the unmet needs in the various geographical areas. These centers would be administered as the States see the need.

Mr. ELLIOTT. Thank you very, very much for a fine report.

Mr. Geer, we will hear your next witness from the workshop.

Mr. GEER. The next section which will be represented will be that of speech and hearing disabilities. The chairmen for that section were Mrs. Margaret L. Washington, from Nashville, Tenn., a person

who has distinguished herself in vocational rehabilitation over a number of years, and Dr. Stanley Ainsworth, chairman of the program for exceptional children at the University of Georgia, and also president of the American Speech and Hearing Association.

Dr. Ainsworth will speak for the group on speech and hearing disabilities.

STATEMENT OF DR. STANLEY AINSWORTH, CHAIRMAN, PROGRAM FOR EXCEPTIONAL CHILDREN, UNIVERSITY OF GEORGIA, ATHENS, GA.

Dr. AINSWORTH. Mr. Chairman and committee members, this report represents 29 individuals representing 10 Southern States who met for the past 2 days in Atlanta. These individuals represented schools for the deaf, vocational rehabilitation, and the profession of speech and hearing with its representatives from training institutions, clinical centers, and public schools.

We explored several categories of needs. I am aware that you know what many of these categories are, because you have been hearing so much testimony in the past about them. We discussed problems involving services, particularly the needs for personnel to provide the services; the problems involved in improving, expanding, and creating training programs; the facilities and services needed to implement help for the speech and hearing handicapped; problems involving dissemination of information about speech and hearing disorders to parents, teachers, medical personnel, social workers, and so forth; and we also discussed briefly some research that is needed to improve the quality and efficiency of these services.

This report, of course, will merely present some of the highlights which we felt were of particular interest to you people at the Federal level. You are, I know, aware of the extreme shortage of personnel in this area. This can be readily determined by a glance at national statistics.

I thought, however, that we should provide you with some regional data which would supplement and bolster the evidence that you already have. For instance, in 9 of the States represented at this workshop, there were an estimated 350 vacancies in speech correction or speech therapy, whichever you wish to call it. These were actual jobs that are available immediately, either because people have left the job and it has not been filled, or because it has been budgeted and personnel could not be found.

In clinical audiology there are 78 vacancies estimated from the people present. You have already heard of the shortage of teachers for the deaf. I would like to present a little different slant on this.

From 20 to 50 percent of the present teachers in the schools represented have not completed certification in this field, so they are relatively untrained. From 10 to 12 percent will retire or reach retirement age within the next 5 years.

The hard of hearing present another area, and it is estimated that 1 percent of school age and possibly the same number of adults need this help. There are very, very few teachers or therapists of this kind in the whole region.

In the area of training programs, it appears that the problems here are threefold. First, we have a problem of utilizing the present programs to full capacity. This involves the need for a great deal of recruitment.

A second problem is the broadening of the training and improving the remedial services in relation to the training programs. We need to include in the training both speech and hearing. Many of our training programs concentrate entirely in the field of speech.

We need to provide more comprehensive and complete diagnostic and therapeutic services by the faculty themselves in order to meet the needs of the severely handicapped and to demonstrate for training purposes. We need to train more personnel at the advanced levels in speech and hearing, as well as at the basic levels.

We need to insure that all staff members in training institutions have advance certification and/or doctoral training.

In the area of the deaf there is a need for more adequately staffed facilities which are situated better geographically. We feel this would be a strong point for recruiting more people and being able to keep them near their homes.

A third area within the training program is that of creating programs which can train teachers at the college level. There are only three doctoral programs in speech and hearing in the region. So we need to expand the present ones, and create new doctoral programs by building up the master's level programs that we have. We are not now training enough people in the South to staff the programs that are already in existence at the college level.

Under the facilities needed for more adequate services, I will just go down through and list some of the types of things without discussing the details or the evidence for these. To a large extent, however, there is little or none of the kind of thing that we are referring to.

We need comprehensive centers for diagnosis and intensive treatment of severe problems of speech, hearing, deafness, language disability, and the associated problems. There is a need for short-term residential centers for those with severe problems.

We could make very good use of mobile clinics for screening, case finding, and preliminary diagnosis. The purposes of this kind of mobile clinic would cover many areas of need. For instance, it could inform the public more adequately through giving them information and demonstration locally. It could aid in the recruitment through this local demonstration. It could help in incidence studies, determine how many of all types of communication disorders we have. It could assist the communities and school systems in setting up programs for the speech and hearing handicapped, and it could provide some needed services for rural areas.

There was a stated need for more vocational centers which could accept deaf for training. There is also a need for preschool clinic centers, for early detection, parent counseling and prevention.

In the area of public information, a great deal needs to be done. One of the most serious weakness in the field is that so few people understand the nature of communicative problems, how they can be helped, where they can get this help, what kinds of help should be sought, and what opportunities this area offers for rewarding careers.

Furthermore, children and adults with problems could be helped substantially more with present facilities and personnel if parents

and teachers could assist more and if a concentrated, coordinated effort from all needed professions could be made. Therefore, we felt that it would be appropriate for the Federal Government to support two kinds of conferences or intensive workshops—those that would be used for informing parents and other professions about what can be done in this field, and another kind for developing procedures for coordination of professional and therapeutic services in localities and regions.

I will not dwell in detail on the area of research, but this is a primary area for lasting and important contributions on both a long- and short-term basis. Principal support is needed to pay especially trained personnel, travel funds to get into the field over a wide geographic area, clerical assistance and statistical services.

There are three facts in our report that point up the importance of additional support for children and adults who have oral communication handicaps:

(1) Speech disorders affect all aspects of a person's life, from early childhood to old age, while he is learning, earning a living, or engaging in social contacts. Serious problems can cause real personal tragedy.

(2) The numbers of those needing help exceed all other types of handicaps.

(3) Most of these people can be helped significantly but are prevented from receiving this help because of insufficient and inadequately trained personnel, scattered facilities, and ignorance concerning the problem.

All of us in the workshop session wish to express our appreciation to the subcommittee for your interest in helping the speech and hearing handicapped.

WORKSHOP REPORT ON SPEECH AND HEARING DISABILITIES: CHAIRMAN, STANLEY AINSWORTH; COCHAIRMAN, MRS. MARGARET L. WASHINGTON; RECORDER, FREEMAN MCCONNELL; KEY MEMBERS, LLOYD GRAUNKE, MINA THURMAN

The section on speech and hearing disabilities met in its first session at 10 a.m. on Monday, January 25, 1960, in the Henry Grady Hotel in Atlanta.¹ Mrs. Margaret Washington opened the first session and asked for self-introductions of all participants present. Dr. Ainsworth spoke next on the purpose of the workshop. He stated that it was the duty of this section to formulate a statement of the needs in the field of speech and hearing in order to give Congress a clearer picture of ways in which Federal assistance can alleviate the current problems. The group is asked to define specific needs and to indicate those which it is felt the Federal Government can reasonably undertake to help solve. Dr. Ainsworth pointed out that for our discussion persons with speech and hearing disabilities would include the deaf, the hard of hearing, and the speech handicapped. He reemphasized that service for this group of the population is needed at all age levels from birth to death.

The first session was used in order for each participant to express specific needs as seen by him. The areas of discussion fell into the several major divisions listed below, followed by a summary of the general statements of needs expressed:

- I. Case finding.
- II. Training of personnel.
- III. Coordination of services.
- IV. Financial problems.

¹ A total of 29 persons registered during the 2-day workshop.

I. CASE FINDING

Although there are educational facilities in each of the States for education of deaf children, the deaf children themselves are often not discovered at an early age nor even by the age of six. Educators in the State schools find it difficult to meet their needs because many are not reported to the schools.

The decisions concerning hearing screening programs often lack uniformity from State to State, as well as from one section of a State to another when not coordinated by a State agency. Different estimates of incidence are obtained because of variations of techniques for screening from one section to another. The need for adequate and effective hearing conservation programs is one of the big needs in the field and perhaps can be met only through much better coordination of State agencies.

Preschool children are seldom included in any of the existing hearing conservation programs. Since this age period is one when the most effective habilitation can be done from the standpoint of preparatory education, speech and language development, and prevention of later permanent hearing damage in the case of hard of hearing children, much more attention should be focused on means of finding preschool children with speech and hearing handicaps.

Programs for case finding are often segmentally approached. Few States have testing programs in speech and hearing at the high school level, yet findings from some surveys show that a large number of adults with hearing impairment date the onset prior to 15 years of age. It was reported that the mean age at which hearing impaired clients were served by vocational rehabilitation is in the late thirties.

One participant who attended the May 1959 Washington Conference sponsored by the Public Health Service and OVR stated that the emphasis on beginning impairment of hearing was strongly reinforced at that Conference. Present programs often find those who already have noticeable problems, but beginning problems of hearing loss are seldom discovered, particularly at the high school level.

Public education of all persons concerned—teachers, medical and rehabilitation personnel—is needed in order to call attention to the number of cases needing help and what can be done for them.

There is a need for investigating the possibility of self-administered tests in this area to circumvent the problems of cost in personnel and time now required.

II. TRAINING OF PERSONNEL

There is a need for assistance from Government agencies in recruiting personnel to take training in speech and hearing. It was suggested that actual promotional activities in each State would greatly enhance the obtaining of students to go into this field. Persons trained in speech and hearing to work chiefly in public relations, and public education and orientation would be very valuable.

Another problem is that many present clinical workers in this field are quite lacking in competence because the pressure for personnel is so great that poor standards are being established in many programs through employment of inadequately trained persons. This conclusion was quoted from the report of the Governors' Conference on the Handicapped in Texas. Dr. Bangs also pointed out that the same report indicated that in this field greater recognition of the need for training of personnel to work with preschool children is drastically needed.

Few vocational counselors have been adequately trained or have had sufficient experience with clients who lack ordinary communication ability. Therefore, the deaf clients and those with language deficit, such as the aphasic, are often not served adequately through present vocational rehabilitation facilities. It was suggested that each region within a State should have at least one vocational counselor who is able to use the manual language in communicating with the deaf, and that such a person also have specific training in dealing with those who have other language handicaps.

Psychologists whose skills are needed in the evaluation of persons having these disabilities are frequently inexperienced with such problems. Very few States represented reported having access to psychologists with adequate experience in working with the deaf to accomplish a thorough appraisal of a client's potentialities—intellectual, vocational, social, and personality. There is a need for Federal grants, therefore, to support residency training in speech

and hearing to help educate psychologists as well as Ph. D. level speech and hearing personnel.

Undergraduate training in speech and hearing needs also to be strengthened. Federal legislation presently bars a number of smaller institutions from receiving assistance in this field because such institutions do not have graduate programs.

Many teachers of the deaf are presently inadequately trained. The number of trained teachers in each State is in the minority. However, the present training centers, although few in number in this region, are not training the maximum number they could. This fact emphasizes that recruiting of people into the field of educating the deaf is a major need. It was pointed out that the critical shortage of teachers of the deaf and the great difficulties in recruiting students might indicate that we should have Federal assistance to support institutions who train teachers of the deaf at the undergraduate level, although Federal assistance is generally reserved for programs at the graduate level where greater quality programs can be assured.

III. COORDINATION OF SERVICES

No one single agency can handle all problems of the speech and hearing disabled since the handicap pervades all age levels, from the nursery-age child to the aged adult. The problem is one, therefore, which transcends any one group or organization. It becomes more important for us to coordinate existing facilities so that all age levels can be adequately served. There is a need for coordinating personnel at both State and regional levels within each State.

In many States trained personnel is the main lack. Even if the cases are found there is still no way to take care of them. Training centers are inadequately staffed.

More emphasis needs to be placed on prevocational training, which can only be accomplished through better coordination of educational and vocational rehabilitation agencies. The needs of the child from 12 to 16 are frequently handled entirely through an educational or clinical type rehabilitative placement. It is in this period of a child's life that he and his family need excellent counseling with careful planning for his vocational future.

Throughout the southern region services tend to be spotty, with quite adequate services in certain sections and very inadequate services in others. Rural areas suffer from the lack of available facilities.

IV. FINANCIAL PROBLEMS

In many instances State support is not obtainable because of restrictive limitations in school regulations and legislative acts. The average daily attendance law of school systems sometimes prohibits the employment of speech and hearing specialists in the schools. There is a great need for legislative uniformity and a better appreciation for the kinds of services needed so that children and adults are not excluded from a service because of a technicality in the regulations.

Funds are greatly needed for physical facilities, treatment centers, and residential centers throughout the South.

SUMMARY OF PRELIMINARY DISCUSSION

The chairman summarized the first morning session to focus on the several areas of discussion.

1. Services

Screening and diagnostic services at all age levels is one of the important needs in this field. These services must include the preschool child as well as the aged adult and the teenager. There is a need for coordination of existing services and addition of provisions or revision of certain regulations now which tend to exclude persons from assistance. The appropriate medical, educational, therapeutic, social, and vocational adjustment followup is necessary for all age levels.

2. Personnel

Recruitment of personnel is an important need for the southern region. Personnel are needed to test, treat, consult, and coordinate. Training of personnel is an urgent need also. The field needs many levels of workers work-

ing within many frames of reference and in many types of positions. The speech and hearing worker is not exclusively a public school worker no more than he is a public health worker, or a university clinic worker, but first of all he is a specialist in the field of speech and hearing and deafness. There need to be training centers in all States, and particularly more training for preschool workers. We have a need to recruit personnel to fill to their maximum the training centers that are now in existence. We need to expand present programs of training and stimulate new programs to supply more and better trained individuals at all levels. Federal assistance is needed to stimulate undergraduate training in teaching of the deaf and training at the master's level, the Ph. D. level, and the post-Ph. D. level in speech pathology and audiology. Residency training programs in medicine and for other allied disciplines is urged to enable these workers to make their major contribution to this disability field through a better understanding of these problems and how they are handled.

3. *Physical facilities*

Clinical facilities should be expanded and Federal help may be needed for both equipment and construction of plants as well as for mobile clinics. Early detection and prevention through improved facilities is an important need.

4. *Research*

There should be studies between States and within States supported by the Federal Government to see how existing services can be coordinated to help those with speech and hearing handicap. There is a great need for a study of the variations in State support and a need to clarify differences between different types of workers in our field. There is a need for broadly conceived legislation which meets the needs of those in speech and hearing, including the multiple handicapped who have speech and hearing problems. There is a great need for research of many types to enable us to understand better the nature of communicative disorders and their management.

NEEDS OF THE DEAF

The chairman and cochairman opened the second session with the statement that it would be best to explore together the needs in the field of the deaf first, followed by the needs in the fields of speech defects and hearing impairment. For purposes of clarification an orienting statement was compiled as follows:

The deaf.—The deaf are those who because of hearing impairment require the special recognized techniques and services for their educational, social, and vocational adjustment. The use of the term "deaf" will be construed to mean those in whom the sense of hearing is so severely impaired that the acquisition of speech and language in the normal manner is not possible; hence, adjustment to their environment must be by utilization of faculties other than the sense of hearing. The deaf, therefore, are those in whom the sense of hearing for all practical purposes is nonfunctional in life, with or without a hearing aid. The great handicap of deafness is one of language, since their ability to communicate is highly restricted and for most, oral communication is impossible without the aid of lip reading. Many are unable to communicate at all except in the manual language, and a considerable number of untrained deaf are seriously limited in any form of language communication.

The experience of the group in this field indicated that most are agreed that the incidence of deafness in children is about 0.3 percent of the school-age population. This is the group whose hearing impairment is so severe as to preclude the acquisition of speech and language in the normal manner, and for whom special educational placement is necessary throughout the major portion of school life to permit full development of their capabilities and their maximum personal and social adjustment.

I. PROBLEMS IN PROVIDING SERVICES FOR THE DEAF

A. *Acute shortage of trained personnel*

The handicap of severe deafness requires specialized services from birth throughout life. Present services are frequently structured so that wide gaps in the age span of services to the deaf person prevail, leaving him without assistance from any existing Federal, State, and local resources during specific periods of his life. For the deaf child, early detection in the first year of life is of para-

mount importance in beginning the long-range program to enable him to participate maximally in society as an adult. Thus, diagnostic personnel whose efforts and evaluations are closely integrated with the fields of otology, pediatrics, neurology, speech pathology, and psychology are sorely needed in the South. Such specially trained personnel in the speech and hearing field are—

1. Audiologists, who must provide thorough appraisal of the auditory status and potential of a child or of a given individual. Periodic evaluation of the hearing status throughout life is required for the deaf child whose growing use of residual hearing influences the type of education, vocational, and other services required.

The audiologist is an acutely needed specialist throughout the southern region. Each school for the deaf should have at least one audiologist on its staff. At present, none of the State schools in the southern region have such a person, but each of the superintendents of schools for the deaf present indicated that he needed such a person. An immediate need for schools of the deaf was 20.

Present vacancies in university clinics and in community and hospital speech and hearing clinics were estimated as follows: 6 each in Tennessee, Virginia, Georgia, South Carolina, and Alabama, and 20 in Texas, or a total of 50.

2. Preschool teachers of deaf children to develop communicative skills essential to learning and social participation during the period in life when the child is most receptive to language formation and development through oral means. It was previously mentioned that most of our present training centers for teachers of the deaf do not give experience with preschool children, and this specialist is now one of the most acutely needed in order to handle effectively the deaf child's problem. Only three institutions in the southern region offer training experience to teachers of preschool children. A maximum of 10 at any one time are being trained in the South, and most of these are being employed in the places where they are trained. Such training is given at the University of Oklahoma, at the Bill Wilkerson Hearing and Speech Center affiliated with Peabody College and Vanderbilt University, Nashville, Tenn., and the Houston Speech and Hearing Center in Texas.

3. Teachers of the deaf for school age children are needed to provide the educational services plus the speech, language, and auditory habilitation that go hand in hand with the special teaching of academic subjects, and which must be taught by a specially trained and skilled teacher. The teachers of the deaf at present fall far short of the demand. Most superintendents present reported that they must now employ teachers who do not meet the existing requirements. A number of schools are staffed with older teachers now facing compulsory retirement and there is no one to supply their vacancies. It was estimated that from 25 to 50 percent of teachers in the residential schools for the deaf are not certified by the Conference of American Executives of Schools for the Deaf. Superintendents from Alabama, Tennessee, North Carolina, and Georgia reported that from 10 to 12 percent of their teachers are ready to retire in 5 years. Presently not more than 8 to 10 teachers of the deaf a year are being trained in the South.

4. Vocational counselors who have special training, in-service or otherwise, with language deficiency are needed. Consultants in speech and hearing services to include deafness, with a minimum of one consultant of each State office, would help solve the problem. Such a person could train other counselors, but there should be an emphasis on training counselors to handle language disabled clients, both those who are deaf and those who are aphasic or have other receptive difficulties in communication. The present situation is one in which many deaf adults feel they cannot be served. One participant pointed out that many deaf believe they can get no help from vocational rehabilitation.

5. Psychologists. At least 55 psychologists who have had training with deaf persons are needed in the South. At present there are less than 10. An estimate from 1 source indicated that only 50 psychologists in the United States are trained to test deaf persons. It was estimated that at least 6 psychologists are needed in Georgia for adults, 6 in Tennessee, 3 in South Carolina, 3 in Oklahoma, 4 in Alabama, 4 in North Carolina, 3 in Louisiana, 5 in Alabama, 10 in Texas, and 5 in Virginia. Psychologists who have spe-

cific training with the deaf to enable more adequate evaluation of intellectual and personality characteristics of the deaf person are greatly needed, both in schools and in adult rehabilitation programs.

6. Social workers, medical and psychiatric, to assist in the planning for families of deaf children and deaf adults are also specialists greatly needed in this field. Not more than five social workers are now known to be working with deaf persons in the southern region. At least 20 are needed immediately in agencies such as Crippled Children's Service, schools for the deaf, and clinics.

B. Services for the deaf

1. *Mobile clinics.*—It was recommended with case finding activities mentioned earlier that Federal funds are needed to support mobile clinics in establishing uniform screening and hearing conservation programs in all States. The mobile clinic would serve for screening, case finding, and preliminary diagnosis, as well as a public education device in the problems of speech, hearing, and deafness. They would provide information for incidence studies in sparsely settled areas, furthermore, and would clarify many unanswered questions on incidence by regions and States.

2. *Preschool facilities.*—There are no more than 10 to 15 preschool facilities in the South at present which purport to train deaf children. States generally do not provide public education funds for preschoolers. Since the deaf child's education must begin as early as possible, from 18 months to 2 years of age if no other handicaps exist in addition to the deafness, it appears that adequate public educational opportunity is often denied the preschool deaf child. A greater number of well staffed preschool programs would do much to reduce the number of children needing full-time educational placement later on. It is important to point out that many young deaf children are functionally deaf, and with special training they may be able to transfer to the category of the hard-of-hearing child. A 55- to 60-decibel loss at birth may result in a condition of functional deafness in a child, who if given special training through nursery and kindergarten programs taught by a well-trained teacher of the deaf may by the age of 6 to 8 be able to become a hard-of-hearing child making more nearly maximum use of his residual hearing. Had he had no training in the early years, however, by the time he was 6 when most residential schools are able to take him, he would have functionally lost the use of his hearing so that he might well function the rest of his life as a severely deaf person with perhaps very limited oral language.

3. *Other types of services.*—Uniform laws at the school-age level and at the preschool level are needed to provide opportunities for day-class programs in a far greater number of cities. Vocational schools which will accept deaf children are also greatly needed throughout the South and a larger number of opportunities for employment. The deaf person can become an independent, contributing member of society. Too many deaf persons are not given adequate opportunity for an education and become wards of society because such opportunities are either not open or are not known to their families.

C. Coordination of services

1. Continuing support of facilities is greatly needed. It is the experience of many participants in the workshop that establishment of programs are often possible with Federal funds but, because a means of supporting personnel cannot be assured, it is very difficult to staff a program. Thus continuing support is needed to assure quality services in personnel. While this may not be a responsibility of the Federal Government, there should be a study of how continuing support can be assured to those clinics and services now existing so that they can meet the needs they are capable of meeting if they could have staff.

2. *Coordination of facilities.*—A great need is the transition between education and vocational rehabilitation. Even when satisfactory educational placement is obtained, there is often no vocational advice prior to the child's leaving school. There is a great need for trained personnel in the trades areas to work with the deaf, both at State and National levels. The 12- to 16-year age span is crucial for making the transition between education and vocation for the deaf child and families need assistance with this planning. There is a need for studies to see how this can be better coordinated than it is at present. This is the age when the educational placement becomes inadequate and when voca-

ional planning is often not possible. However, a greater exploration of opportunities and potentialities of young deaf people entering their teens would do much to alleviate present inadequacies in this program.

II. TRAINING OF PERSONNEL

A. Recruitment

One of the biggest problems in training personnel to work with the deaf is recruitment. Present programs for training teachers of the deaf are not working to full capacity. It is much easier to attract young people into the allied fields of speech pathology and audiology than into teaching the deaf. Six of the training centers in the southern region which are credited by the Conference of American Executives of American Schools for the deaf have no students. North Carolina has 6 students and could train 20. Tennessee trains from 5 to 10 persons a year. Texas has none at present.

B. Traineeships

Traineeships to encourage young people to go into this field are needed. Because of the critical shortage of teachers of the deaf, it is the opinion of this group that funds for teachers of the deaf are needed at the undergraduate level. The present need for teachers of the deaf cannot be filled unless we draw upon undergraduate workers. The teaching of the deaf curriculum lends itself to undergraduate levels, and the bachelor's degree represents a sufficient academic proficiency level, since in this field diagnostic skills are not as important as teaching skills.

C. Training emphasis

Training centers today much more than in the past should emphasize in their training programs the utilization of hearing potential in children.

D. Training grants

There is a need for grants to institutions to finance education of the deaf programs. It is recognized that it is difficult to train large classes of teachers of the deaf, and thus this type of training will always be expensive and may require subsidization. Additional centers, other than the three approved by the Southern Regional Education Board, are felt to be needed if we meet the critical need for teachers of the deaf. Institutions need funds to staff them with continuing support assured if we are to meet this great need. It is recommended that the preliminary work done by the Southern Regional Education Board be utilized and their recommendations on programs for teachers of the deaf be implemented.

III. FACILITIES

A. Audiologic facilities

Audiologic facilities in residential schools for the deaf are needed, as well as in many more community, university, and hospital clinics, for the diagnosis and appraisal of deaf persons. Such units, working with preschool special classes, school age day classes, residential schools, and vocational and psychological services in a community, are potentially of great value in alleviating the problems of deafness.

B. Residential facilities for the adult deaf

A report from the recent Fort Monroe Vocational Rehabilitation Conference concluded that deaf adults are not able to fit into existing rehabilitation centers, which are often more specially designed for the orthopedic and other motor handicaps. It was suggested that special rehabilitation centers for the adult deaf be established on a regional basis, with both outpatient and inpatient facilities. Such centers could be appended to those which are already existing or could be a separate facility. The important point to be stressed is the uniqueness of the adult deaf person who cannot communicate readily through hearing, making his communication problem so great that the regular type rehabilitation center program is not able to meet his needs. We are not meeting the needs of this segment of the adult population and must make greater efforts to do so.

IV. PUBLIC AND PARENT INFORMATION

There is need for financial assistance in the preparation of public education material, including brochures and exhibit materials.

Federal assistance for regional workshops were recommended to train personnel to conduct local workshops. These should include nurses, psychologists, and community agency workers.

There should be more emphasis on speech and hearing and teaching of the deaf on high-school career days. There is need for exhibits, films, brochures, posters, and photographs, all of which are expensive and often not possible in the ordinary budgets of training institutions.

NEEDS OF THE SPEECH AND HEARING HANDICAPPED

The needs of the population with speech problems and with hearing problems less severe than those implied by the term "deafness" will be considered simultaneously in the discussion below.

ORIENTING STATEMENT

For purposes of the discussion below, "speech problems" will imply expressive problems of communication resulting from such organic disorders as cerebral palsy, laryngectomy, cleft palate, and voice pathologies, or from functional problems such as delayed speech reflected in infantile speech patterns and production, from articulation errors of substitution, omission, and distortion of speech sounds, and from stuttering. Hearing impairment here includes all those who have a handicapping hearing loss for speech, but whose residual level of hearing is sufficient to be utilized effectively in communication, if specially trained and if special aids such as hearing aids, lip reading, and auditory training are made available and utilized effectively.

INCIDENCE

Incidence of speech problems at the preschool level are not known and this group questioned the reliability of available estimates. The participants agreed that incidence of speech problems in the 5- to 19-year-age group is about 5 percent in the southern region and over 19 about 3 percent. The incidence of hearing handicap, in addition to the deaf mentioned earlier, was agreed to be about 1 percent of the school-age population.

A report on a special study in the State of Virginia in 1953 revealed that of an estimated incidence of 10,565 hard-of-hearing children, only 1,139 were actually revealed through school and health records. This estimate was based on incidence studies on a national level and can be relied upon as being reasonably accurate. Therefore, local, State, and community agencies failed to reveal the existence of these nearly 9,000 children in 1 State.

Estimates of incidence among the preschool-age group were not felt to be reliable. Estimates of adult incidence vary widely, dependent on where we define the level of handicap to begin. The group thought that about 3 percent of the adult population would need audiologic services.

The handicap of hearing loss is importantly related to age of onset. A mild hearing problem may be quite severe in its effects on a young child, although not nearly as apparent in an adult who has well-established speech and language proficiency. Beginning hearing impairment, mild, moderate, and severe levels, are all included in incidence. A large group of the adult population acquire hearing impairment not only from causes such as otosclerosis and other types of ear disease, but also from such sources as industrial and military noise exposure. Incidence of hearing impairment is quite great in infancy and early childhood when ear infections and middle-ear diseases are quite prevalent, resulting often times in permanent hearing impairment. Incidence of hearing loss tends to decrease at puberty, but rises again in the late teens and through the twenties and thirties, as a result of otosclerosis, a disease of the middle ear causing a bony growth formation impeding sound passage, and affecting about 0.1 percent of the population. The incidence of hearing impairment beyond the thirties decreases until after 50, after which time it becomes markedly on the increase with each year of increasing age. The causes of hearing impairment resulting in damage to the hearing nerve are legion and may result from sinus, colds, flu, or any disease in which there is high temperature or from any condition of toxicity in the body. These types of hearing problems are not confined to any one age group.

I. PROBLEMS IN PROVIDING SERVICES FOR THOSE WITH SPEECH DISORDERS AND HEARING IMPAIRMENT

A. *Personnel needs*

1. *Estimate of present shortage.*—Needs for specially trained personnel in speech and hearing were estimated by the various persons present. A conservative estimate of vacancies for positions which are now budgeted was 390 in the States represented. The State of Florida has a need for as many as 75 persons at present, North Carolina 50, South Carolina 10, Virginia 20, Alabama 10, Tennessee 50, Mississippi 15, Georgia 30; in the State of Texas last year 299 units in school systems were set up but only 90 were filled. These vacancies represent positions for which budgets have been established or would readily be established if a trained person became available, and do not include anticipated future needs. In Atlanta, Ga., the speech clinician-student ratio was estimated to be 1 per 11,200, in Fulton County 1 per 12,600, and in DeKalb County 1 per 21,000. Obviously, these school systems are inadequately staffed at present. Many areas of the South are completely without services of any kind. South Carolina has 1 speech specialist to every 30,000 schoolchildren.

The need for audiologists who specialize in the diagnosis and rehabilitation of the hearing impaired has been discussed above under personnel needed in the area of the deaf. It was the opinion of the participants in this section that as services in these special fields are made available, the need for personnel increases. Therefore, present estimates are minimal and in no way are considered representative of future needs which will be much greater.

2. *Need for advanced level personnel.*—This group wishes to emphasize that personnel at advanced levels are needed in the South where those with advanced training, particularly, are in critical shortage. Speech pathologists and audiologists with advanced certification are needed in medical centers, where it is important that the profession be represented with capable persons highly trained, who can work independently and integrate their skills effectively with those of other disciplines, rather than under the direction of and supervision of other disciplines.

3. *Staffing mobile clinics.*—It was further pointed out that with the recommendation that mobile clinics be established throughout the region to assist in incidence studies, public education, and bringing speech and hearing services and specialists to outlying communities, additional personnel would be needed to staff such clinics. Existing clinics and centers could not spare their personnel to do such work, which would require setting up full-time positions under one of the State agencies, probably.

4. *Electronic and acoustic technicians.*—A generally unmet need in all schools for the deaf and university and community clinics is for electronic and acoustic technicians. This type of personnel is greatly needed in the proper administration of clinical and educational programs utilizing modern and highly specialized electronic and technical equipment, from the standpoint of services as well as in research and training of students to work in this professional field. Federal assistance here would be helpful in establishing such a precedent since many budgets do not support this type of staff person.

B. *Services for those with speech disorders and hearing impairment*

1. *Needs of the hard of hearing child.*—While in most cases education in the regular classes for the speech defective child is possible, the child with a hearing loss more often needs special educational placement. The plight of the hard of hearing child was felt by some participants to be extremely serious. He is said to be the forgotten child, since many school systems and State departments fail to recognize his problem. Hard of hearing children often grow up as deaf children because of inadequate programs for their education. There is a need for special classes in the public schools for this group in almost every county. This provision would relieve much of the load on residential schools for the deaf, which could then direct their efforts for the more specific purposes for which they were established—the severely deaf. It would be assumed that the improvement in the education of the hard of hearing individual would tend to reduce the need for intensive rehabilitative services later. While many of the hearing impaired children are able to attend the public schools, they will frequently and most often need special classes in the early years of their school life until language is well established. There is much research evidence which sub-

stantiates that the child with even a mild to moderate hearing loss is often deficient in language development. Therefore, the schools need persons especially trained in hearing to work with this segment of the population, whose need is language habilitation.

It was estimated that at present there are not more than five to six programs in the southern region for public school special classes for the hard of hearing child. The four known ones are located in Nashville, Baton Rouge, New Orleans, and Memphis.

2. *Need for more and better diagnostic and treatment centers for speech and hearing disorders.*—There is a great need for more comprehensive diagnostic and intensive treatment centers, which are now widely scattered, and many are inadequately staffed to evaluate thoroughly the various speech and hearing disabilities. Cooperative efforts between education and vocational rehabilitation to integrate their planning for speech and hearing handicapped individuals is also of paramount importance in helping these persons make their maximal adjustment to society upon reaching adulthood, as well as assisting those who acquire problems of communication as adults.

C. Coordination of services

It is important to coordinate services now existing so that close cooperation with medicine and other disciplines is maintained. Adequately coordinated and effective case finding and program planning require an increased number of well trained persons placed in education and health services and agencies in each of the States. Appropriately trained speech and hearing personnel in the departments of education and health, for example, would assist in training and orienting other disciplines to these problems. A large number of persons with speech and hearing disabilities are now not being referred to existing facilities, and many referral sources are not taking advantage of early assistance. The aphasic, the postlaryngectomy patient, as well as young children with deafness and organic speech difficulties, all can make the most gains if detected immediately and if programs of habilitation and rehabilitation are begun at the earliest possible time, as judged by competent speech and hearing personnel.

II. TRAINING OF PERSONNEL

A. Introductory statement

There is a basic core of knowledge which permeates the training of all persons working in any of the three areas of communicative disorders—speech pathology, audiology, and education of the deaf. Whether a position is held in public schools, clinics, hospitals, health and voluntary agencies, or community centers, there is a common core of information for all workers.

B. Explaining and broadening staffs of training departments

Training programs need to be expanded in several dimensions. There should be broadening of the training staff to include faculty members well trained in both the speech and hearing fields. Every training program should be staffed with personnel holding advanced clinical certification in the American Speech and Hearing Association and/or training at the doctoral level.

Every training program should be able to offer a curriculum preparing students for advanced certification in one or both areas—speech and hearing.

Training institutions with one or two faculty members who represent all areas in communicative disorders are inadequate. Faculties should be increased both to provide a higher level of clinical competence in graduates and to anticipate results of improved recruitment methods bringing larger enrollments. Departments should be graduating more persons competent to staff other training programs.

It is specifically recommended that each training institution broaden their training to include more work in hearing and that we develop hearing specialists in the training programs. Comprehensive training centers, which include work in education of the deaf, speech pathology, and audiology in one department dealing with communicative disorders, are highly recommended.

C. Provision of advanced graduate training

Federal assistance is urgently needed which would (1) improve present programs offering graduate instruction and (2) make possible the establishment of new programs of graduate study. There is particularly a great need for more doctoral programs in the Southern region. It is noted that only three institu-

tions in the Southern States represented are now giving a doctoral program in speech pathology and none in audiology. These programs cannot possibly fill present needs for advanced level personnel.

III. FACILITIES

A. Residential programs

There is a need for short-term residential facilities for persons with severe speech handicaps where intensive training may be obtained. Such facilities might well be part of such a similar facility recommended for the deaf. One director of a hearing and speech center estimated that 90 percent of adults seen cannot be handled adequately without residential treatment, and that 30 percent of children cannot be adequately handled. In other words, the severer problems require more intensive treatment than present out-patient treatment facilities permit. Regional residential centers would also provide more complete and adequate rehabilitation for individuals in outlying areas. The success of the few facilities available (summer camps for children) testify to the value in terms of conservation of human resources.

B. Mobile clinics

The need for mobile clinics has been previously discussed. This type facility would enable any citizen of any age to bring his problem to a trained person, from whom he would receive preliminary diagnostic service and counseling on what he might anticipate in the way of assistance with his problem. Furthermore, such mobile clinics would contribute to accurate studies of incidence of speech and hearing problems which at present are vague. Mobile clinic staff personnel could assist in setting up new programs in communities and public schools.

C. Continuing support

It was recommended that supporting grants be made to clinics newly built for the first year to take care of the resulting additional case load. In construction of new facilities or expansion of existing physical facilities, provision needs to be made for assistance similar to that through the Hill-Burton Act. Federal assistance is also needed for equipment to provide proper diagnostic and intensive treatment, since the equipment needed is both highly specialized and expensive.

IV. PARENT INFORMATION AND PUBLIC EDUCATION

Here the same recommendations as were made for the deaf would apply.

SUMMARY—AREAS IN WHICH FEDERAL ASSISTANCE IS RECOMMENDED

I. Training of personnel

A. Student traineeships.—It is recommended that traineeships be made available to students who wish to prepare in this professional field.

1. In the area of the education of the deaf a critical need for special classroom teachers exists. It is the opinion of this section that the shortage is so critical as to require the support of students at the undergraduate level. In addition, graduate scholarships and fellowships are also needed.

2. In the fields of speech pathology and audiology substantial scholarships should be made available which would attract students into this field for graduate study at both the master's and Ph. D levels.

3. Funds are needed for the continuing professional advancement of, and increased competence in, personnel who deal with speech and hearing disabilities, through programs of postdoctoral residency study in qualified training centers.

B. Training grants to institutions.—The critical shortage of personnel, together with the great cost of training specialists in the fields of deafness and speech and hearing disorders requires some form of Federal assistance in the ways of training grants to institutions themselves. Grants are needed for faculty, for specialized and highly technical equipment used in evaluation of speech and hearing problems and for graduate research, and for improved or new physical facilities. In addition, funds for recruitment endeavors are needed. This support should include funds for exhibit materials and brochures for which budgeting is often impossible through regular channels. These training grants should allow for—

1. The improvement of training centers now in existence, and
2. The creation of new centers.

II. Problems of increased services

A. *Mobile clinics.*—It is requested that there be some form of Federal legislation to employ such facilities as mobile clinics which could be used in screening, case finding, and preliminary diagnosis of speech and hearing problems. The purpose would be threefold: (1) To educate the general public regarding speech and hearing problems and what can be done to remedy them through bringing the specialized personnel into outlying communities, (2) to gather data for incidence studies which could be more accurately gathered throughout a State or region to determine the true proportion of speech and hearing handicaps, and (3) to assist in recruitment of personnel to the professional fields of speech and hearing.

B. *Diagnostic and treatment centers.*—Federal assistance is also recommended to assist in the establishment of more comprehensive diagnostic and intensive treatment centers, to include physical plant construction, equipment, and temporary support of staff. Further, it is recommended that short-term residential facilities be established for those persons with speech and hearing impairment for whom the ordinary rehabilitation center is not appropriate. The success of a few such short-term programs demonstrates the value to rehabilitation, and while the initial cost is great, the economic returns to the community and to society outweigh these costs. Present clinics working on an outpatient basis cannot serve this rehabilitation need. Such facilities provide group therapeutic values which can only come from the supportive opportunities provided.

In addition, it is recommended that there be special adult rehabilitation facilities for the severely deaf not presently rehabilitable to provide training in social acceptance, emotional, vocational adjustment, and communicative skills. These persons with this type of communication handicap do not fit into the ordinary concept of the comprehensive rehabilitation centers.

C. *Continuing support.*—Federal funds for contractual grants to assist smaller clinics during an initial period of 3 to 5 years to enable them to enlarge staff to provide the much needed services which present facilities do not permit.

III. Coordination of services

A. *Conferences.*—Regional conferences should be stimulated through Federal assistance, the purpose of which would be to support interdisciplinary efforts for better coordination of facilities now in existence. Such regional conferences supported federally should train speech and hearing personnel to hold such conferences on a local or State basis.

IV. Research

A. *Incidence.*—Present estimates of the incidence of speech and hearing problems vary widely from report to report. A more valid study of incidence to include both urban and nonurban populations regionally is recommended for a national federally supported project.

B. *Area.*—Basic research in audition, speech, and linguistics.

C. *Research studies.*—1. To demonstrate the value of better coordination of education and vocational planning in consideration of the long-term needs of an individual.

2. To determine the value of comprehensive regional facilities for the adult deaf who have had little or no previous assistance.

3. To determine the language and vocational prognosis for brain injured, aphasic, and other seriously handicapped who need long-term treatment.

D. *Development of diagnostic tools.*—1. Psychologic instruments suited to those without language.

2. Self-testing devices to make mass screening programs more economical of time and specialized personnel.

MR. ELLIOTT. Thank you, Dr. Ainsworth, for a fine report.

MR. GEER?

MR. GEER. The cochairmen of the section on chronic disabilities were Mr. E. B. Bowman, executive director of the Mobile Rehabilitation Association, Inc., Mobile, Ala., and Mr. W. R. Burris, supervisor of the department of education, Jackson, Miss.

The spokesman will be Mr. Burris, a very capable supervisor, from Mississippi.

Mr. ELLIOTT. We are happy to have you, Mr. Burris, and look forward to your report.

STATEMENT OF WAITUS R. BURRIS, SUPERVISOR OF SPECIAL EDUCATION, STATE DEPARTMENT OF EDUCATION, JACKSON, MISS.

Mr. BURRIS. Mr. Chairman and members of the committee, it is pretty obvious that at the midway point of these reports there is quite a bit of duplication and probably overlapping. I assure you it was not intended that way, as not one of us in the different committees knew what was transpiring in the others. For the sake of emphasis, perhaps, I will go ahead with the summary of the items as they were discussed and unanimously agreed upon in our group.

This report deals with a relatively large number of persons who are handicapped by disabilities of such severity and length or duration that they require special assistance to be raised or restored to a condition of independent living, vocational and social adjustments, or educational competence.

It might be noted that although there is some overlapping, this is not designed to be that way.

Enthusiastic agreement and support were given to the following observations and recommendations: It was recommended that there be developed in Federal legislation or by expressed intent provisions for advisory groups on the National, State, and local level to coordinate public and private agencies, organizations and individuals concerned with the problems of chronic disabilities.

No. 2. That there be provided by Federal assistance on a pilot basis comprehensive evaluation, appraisal or diagnostic clinics for persons of all ages, to explore their physical, psychological, social, emotional, and educational characteristics, not to identify weaknesses or abnormalities, but to evaluate their full potential.

In addition to the usual community resources, this would require well-staffed facilities where the clients could spend several days and nights as needed to get the required studies, tests, or examinations. After these pilot projects have demonstrated their value in effecting this, further consideration could be given to the expansion of such clinics.

No. 3. That Federal funds on a State matching basis be provided for the construction and equipment of needed education and rehabilitation facilities and sheltered workshops; also, that appropriations be made for the maximum use, support, and extension of such existing facilities.

No. 4. That Federal grants, fellowships, and scholarships be made for the training and teaching of the professional personnel required to adequately staff a comprehensive evaluation or rehabilitation and education facility.

Some of these would be therapists, teachers, psychologists, psychiatrists, nurses, social workers, counselors, administrators, researchers, and various medical specialists.

No. 5. That laws in the field of social security, public assistance, and workmen's compensation be made to encourage the disabled individual to take advantage of rehabilitation services.

No. 6. That there be a continuation and extension of support for research on the chronically disabled. This might well be done in evaluating the effectiveness of the existing or recommended evaluation of clinics and rehabilitation facilities, and also some definite plan of cataloging and disseminating results of research should be devised.

No. 7. That note be taken and support given to the principle of designing public housing, of public schools and other public buildings to accommodate the chronically disabled.

No. 8. That overall Federal legislation be enacted to deal with all types of handicapped persons rather than piecemeal legislation limited to specific areas of exceptionality or handicap.

No. 9. The section on exceptional children and youth of the U.S. Office of Education is woefully understaffed. It is recommended that the staff be expanded to include specialists in all the various areas of exceptionality so that better service can be given to the special educational programs in the various States.

No. 10. And lastly, to give better service to the chronically disabled and to establish better standards for sheltered workshops there should be an evaluation of existing workshops and a consolidation of community workshops.

This would provide more economical administration, sharing of professional personnel, and more thorough exploration of contracts, including Federal contracts.

This completes our prepared report. On behalf of the workshop group, I would like to thank you for the opportunity to present it.

WORKSHOP REPORT ON CHRONIC DISABILITIES

Your cochairman of the workshop group on chronic disabilities are keenly aware of the grave responsibility placed upon them in conveying to you a report of their deliberations, conclusions, and decisions. This group was composed of very able, sincere, and conscientious men and women representing various areas of care, education, and rehabilitation of handicapped children and adults and acutely sensitive to the needs of such persons. Although the items were thoroughly and intelligently discussed from various points of view the decisions reached were by complete unanimity.

This report deals with a relatively large number of persons who are handicapped by disabilities of such severity and duration that they require special assistance to be elevated or restored to a condition of independent living, vocational and social adjustment or educational competence. Although no figures on a nationwide scientific study of the incidence of persons classified as chronically disabled are available, it is obvious that there is an appreciable and increasing number of them. Educators and rehabilitation counselors, because of the unavailability of personnel and facilities, are constantly faced with the momentous problem of these unfortunate citizens.

The workshop group respectfully invites your attention to the following recommendations and observations:

1. Advisory coordinating groups

There obviously is overlap and duplication in services to the chronically disabled in view of the various independent programs designed to serve them. It is therefore recommended that there be developed by legislation or policy provisions advisory groups on the national, State, and local levels to coordinate public and private agencies and organizations concerned with the problems of the chronically disabled.

2. Evaluation, appraisal, or diagnostic clinics

Before any worthwhile and lasting assistance can be given the handicapped it is necessary to explore their physical, psychological, social, emotional, and educational characteristics, not to identify weaknesses or abnormalities, but to evaluate their full potential. This requires, in addition to the usual commun-

ity resources, well-staffed facilities where the person can spend several days and nights, as needed to make the required studies, tests, and examinations. It is recommended that Federal assistance be given the States on a pilot or demonstration basis to establish, staff, and maintain comprehensive evaluation, appraisal, or diagnostic clinics for persons of all ages.

3. Rehabilitation and education facilities

There would be little value in evaluation and diagnosis with the present dearth of rehabilitation and education facilities. It is recommended that Federal funds, on a State matching basis, be provided for the construction and equipment of needed rehabilitation and education facilities and sheltered workshops. It is also recommended that appropriations be made to provide for the maximum use, support, and extension of such existing facilities.

4. Grants, fellowships and scholarships

There is a real paucity of trained therapists, teachers, psychologists, nurses, social workers, counselors, researchers, administrators and various medical specialists to staff rehabilitation and education facilities when they are provided. Because of the length and cost of such training few can afford it without financial assistance. It is therefore recommended that Federal grants, fellowships and scholarships be made for the training and preparation of the professional personnel required to adequately staff comprehensive evaluation, rehabilitation and education facilities.

5. Liberalization of laws and regulations

It is often found that handicapped persons are reluctant to enter a vocational rehabilitation program for fear of losing their social security, public assistance or other income, either their own or members of their families. It is also found in some instances that second injury clauses in workmen's compensation laws prohibit the handicapped person's securing employment. It is recommended that liberalization of laws and regulations in the fields of social security, public assistance, and workmen's compensation be made to encourage the disabled individual to take advantage of rehabilitation services.

6. Support for research

We are living in an age of increasing emphasis on research to find out the what, why, and how of doing things. More and more the need or justification for action is based on scientific research. There is a great need for study of the problems of the handicapped. There also appears to be a need for cataloging and disseminating results of research so it can be more widely utilized. It is recommended that there be a continuation and extension of support for research on the chronically disabled. Some of this might well be done in evaluating the effectiveness of existing or recommended evaluation clinics and education and rehabilitation facilities.

7. Design and construction of buildings

Note might be taken of the fact that there have been some buildings designed and constructed with the needs of the handicapped in mind. There is no real advantage of steps over ramps except possibly conservation of space in some specific situations, while there is a great advantage to the handicapped of ramps over steps. Also, elevator doors and other apertures should be made large enough to adequately take care of wheel chairs. It is recommended that support be given the principle of designing public housing, public schools and other public buildings to accommodate the chronically disabled.

8. Comprehensive legislation

There is always the danger of having legislation enacted for the benefit of small segments of the handicapped population because of the influence of pressure groups with narrow interests. It is recommended that Federal legislation be enacted to deal with all types of handicapped persons alike rather than piecemeal legislation limited to specific areas of exceptionality or handicap.

9. Strengthening the staff of the U.S. Office of Education

The Section on Exceptional Children and Youth of the United States Office of Education is woefully understaffed. There are few, if any, of its personnel with the time or special preparation to give advice, information or special assistance to the various States. With a full staff of consultants much assistance could be given in collecting and disseminating data from over the Nation, doing

or promoting research, advising with new State programs, and other related services. It is recommended that the staff of the Exceptional Children and Youth Section of the U.S. Office of Education be expanded to include specialists in all the various areas of exceptionality.

10. Standards for sheltered workshops

To give better service to the chronically disabled and to establish better standards for sheltered workshops, there should be an evaluation of existing workshops and a consolidation of community workshops. This would provide more economical administration, sharing of professional personnel, and more thorough exploration of contracts, including Federal contracts.

We deeply appreciate the opportunity of presenting this report and trust it will be of value to you in planning legislation on special education and rehabilitation. We are grateful for your interest and efforts on behalf of the handicapped. If at any time we can be of further assistance feel free to call on us.

Mr. ELLIOTT. It has been a real pleasure to have you, Mr. Burris.

Mr. Geer, before you make your next announcement, I see that the probate judge of this county has come into our audience, the Honorable Graf Hart.

Judge Hart, may I thank you for the coffee and refreshments that you sent up during our recess.

Mr. GEER. Our next section will be the section on the mentally ill and emotionally disturbed. Chairing this group were Dr. Nicholas Hobbs, chairman of the division of human development, the Peabody College in Nashville, and Mr. John W. Forrest, supervisor of special disability services in the division of vocational rehabilitation, in the Georgia Department of Education.

Neither of these chairmen were able to be present today, and so they designated Dr. Warren Findley, a member of that group, assistant superintendent of pupil personnel services of the Atlanta public schools. Dr. Findley has wide experience working with guidance and personnel work of the type that is represented by his group and will make that report.

Mr. ELLIOTT. We are happy to have you, Dr. Findley. You may proceed in any manner you see fit.

STATEMENT OF DR. WARREN FINDLEY, ASSISTANT SUPERINTENDENT, PUPIL PERSONNEL SERVICES, PUBLIC SCHOOLS, ATLANTA, GA.

Dr. FINDLEY. Thank you, sir.

Mr. Chairman and members of the committee, this section on special education and rehabilitation of emotionally disturbed children began its work by seeking a definition of emotionally disturbed children, since this is an area that is in some ways new, and in which this term is used variously. We were fortunate to find and to be able to adopt a rather simple and straightforward definition given by Dr. Lois Murphy, of the Menninger Foundation, at a meeting of the North Carolina Conference on Handicapped Children in 1958, which was devoted to the emotionally disturbed child.

She states:

By an emotionally disturbed child, we ordinarily mean a child whose emotional responses to the stresses of his life are disrupting to his growth and his relationships with his environment.

The report from this group falls naturally into two parts, one having to do with special education provisions in the schools, and the second having to do with rehabilitation.

Turning first, then, to the area of special education, it was the experience of all of us that emotionally disturbed children present a great problem to themselves, their teachers, their classmates, and society as a whole. Moreover, it is clear that these children can and should be identified early, before their personal lives are deeply affected.

We feel that the present status of know-how in the education of emotionally disturbed children is such that much can be done immediately if shortages of personnel can be met. Meanwhile, we should encourage pilot projects to explore intensively the most promising new approaches now emerging, promote a survey of the scope of the problem in terms of numbers of children nationwide who are in varying degrees disturbed and in need of help, and support basic research in child development and other relevant areas of behavioral science.

To accomplish these goals, we propose the following "package" of four recommendations:

(1) To bring immediate help to those working with emotionally disturbed children:

(a) Make allocations through State agencies of Federal funds—perhaps to be matched as under title V of the National Defense Education Act of 1958—for support of the services of school psychiatrists, school psychologists, school social workers, guidance counselors, and remedial teachers. These allocations should be usable to provide facilities, equipment, materials, and clerical assistance, as well as for salaries of professional personnel.

(b) Make grants to individuals and training institutions to provide training opportunities to help decrease the shortage of qualified—

(1) school psychiatrists;

(2) school psychologists;

(3) school social workers;

(4) guidance counselors, particularly at the elementary school level;

(5) remedial specialists.

(c) Make grants to individuals and institutions to furnish background training to teachers and school administrators, who must continue to be the first line of defense against developing emotional difficulties. This should include not only direct grants for instruction in principles and practices of good mental health, but grants to train "professors of mental health in education" to provide this instruction.

(2) To encourage pilot studies of new approaches:

(a) Grants to support citywide and/or countywide demonstrations of new procedures on a scale sufficient to show that can be done when these procedures are applied intensively. For example, a combination of day care centers and residential treatment in addition to special teachers in school and social work with whole families.

(b) Grants to support smaller-scale efforts to study and evaluate what specific new practices can mean if added to typical school arrangements.

(3) To determine the scope of need nationally in order to give better direction to the direct applications already recommended:

(a) Grants to a central agency, to work through States, to determine the numbers and proportions of children at each age level and type of community who need various types of help, such as—

- (1) help by teachers;
- (2) help within the school setting guided by professional specialists;
- (3) day care at special centers;
- (4) short-term residential treatment for observation and diagnosis;
- (5) long-term residential treatment for reeducation.

(4) To provide for development of new techniques and understanding:

(a) Grants in support of child-development studies.

(b) Grants in support of studies of physiological and psychological factors.

Rehabilitation aspects: We recognize that the emotionally disturbed, if they are to make an adequate adjustment, must be returned to the community as employable persons. Since there are such great numbers of these people currently in the population, and since the numbers are increasing rapidly with improved diagnostic treatment techniques which make it possible to return these people to the community instead of leaving them in mental institutions, the need for increased effort in the area of rehabilitation becomes even more acute.

This committee proposes recommendations in four broad areas to deal with these problems: (1) Improved facilities; (2) training of personnel; (3) program to develop and expand employer acceptance; and (4) research.

(1) Facilities:

(a) We want to go on record as recommending extension and continuation of existing programs for establishment of evaluation and reeducation programs such as—

(1) Workshops for evaluation, job orientation, and work adjustment;

(2) Training centers in key population and/or geographic areas where psychotherapy, domiciliary care, and vocational guidance is provided;

(3) Halfway houses to assist hospitalized or other emotionally disturbed people who need such a service to bridge the gap between sickness and total adjustment to community living;

(4) Intermediate facilities between hospital and local communities to which these disturbed people can return.

(2) Training of personnel:

(a) Outright Federal grants to States so as to provide training for persons to work with the emotionally disturbed—

(1) To provide upgrading of skills of vocational rehabilitation counselors who are currently employed in vocational rehabilitation programs through graduate training. We suggest something like three-quarters base salary plus tuition and supplies. Give them leaves of absence for this training.

(2) To train employment counselors.

(3) To develop group therapy, group counseling, and group work skills in ministers, school counselors, vocational rehabilitation counselors, social workers, welfare workers, psychologists, general duty nurses, public health nurses, parole and probation officers, and physicians, so that a minimum number of professionals in the community may reach a maximum number of emotionally disturbed people and augment services already given by psychiatrists.

(4) To provide orientation into the problems of the emotionally disturbed for personnel men in industry, police officers, union officials, community health and welfare organizations, jurists, and the like.

(5) To provide upgrading of skills of personnel working in correctional schools so as to improve their skills in working with the disturbed inmates.

(3) Program to develop and expand employer acceptance:

(a) Give industry encouragement, through tax exemption or other financial incentive, to develop jobs for emotionally disturbed in industry. This might include development of job orientation and adjustment programs for emotionally disturbed new employees, clinical personnel to give supportive help to new employees during early employment adjustment period, et cetera.

(4) Research: Give grants to promote—

(a) Research into the rehabilitative counseling process to ascertain what is good practice;

(b) Research to help develop new methods for rehabilitation of the emotionally disturbed;

(c) Evaluation of jobs to determine the emotional stresses involved and personality characteristics essential for good job performance in various types of employment.

In no instance have we attempted to specify the costs involved in carrying out these programs. It is felt that such estimates can be made more adequately and realistically by a central body that has before it the recommendations emanating from the six regional conferences.

WORKSHOP REPORT ON THE MENTALLY ILL AND EMOTIONALLY DISTURBED

The section on Mental Illness and Emotional Disturbance was composed of the cochairmen, representing rehabilitation and special education, twenty (20) delegates of varying professional orientation and background (including psychiatry, psychology, rehabilitation, social work and education), and two (2) observers.

It was immediately decided that the group would concern itself with the problem of mental illness and emotional disturbance as it affected the whole age range from childhood through adulthood. However, for practical purposes, it was decided that we should divide our discussion into two parts—special education and rehabilitation—and discuss each separately so that the entire group could focus its attention without distraction on the particular problems and unmet needs of each of these two groups. This procedure worked well.

The problem of the definition of mental illness and emotional disturbance came up early in the discussion. It was decided that the group would be planning programs for "any person whose emotional responses to the stresses of his life are disruptive to his growth and his relationship to his environment." Thus, the group would concern itself with all mentally ill and emotionally disturbed persons whether hospitalized or not, whether children or adults.

Since it was decided to explore the needs in special education first, the discussions on Monday, January 25, 1960, were focused on this particular area of interest and need. The following seven (7) points summarize this particular discussion:

1. Teachers have become more alert to emotional problems in children but they very much need the help of guidance people, school social workers, and school psychologists to assist them in finding solutions for the children they have identified.

2. While mental health clinics are available in larger communities, they are not sufficient to meet demands for service. There is an urgent need of finding ways of serving children in smaller communities and rural areas, either by bringing the children to the centers or by taking the services to the children, possibly through traveling, diagnostic, and treatment teams.

3. Classroom teachers need more instruction and better supervision in supportive and understanding relationships with disturbed children in the regular classroom.

4. College professors particularly need to be alerted to their responsibility for identifying students in need of mental health services.

5. One of the most critical areas of personnel shortage is that of remedial education. The problems of emotionally disturbed children are reflected in an exacerbated by deficiencies in reading, spelling, arithmetic, and other skills. Personnel trained in remedial education are sorely needed.

6. Utilization of techniques that are less traditional for school programs, such as group therapy, must be employed to extend the effectiveness of mental health specialists.

7. There should be a study of the school as a source of emotional disorders in children with a view toward revision of school programs to make them supportive of the total development of children, affective as well as intellectual.

The discussions on Tuesday, January 26, 1960, were focused on the needs of rehabilitation with an attempt being made to tie the programs of special education and rehabilitation more closely together. This closer tie seemed desirable so as to give more continuity of service to the emotionally disturbed and mentally ill. The following seven (7) points seem to summarize this particular day's discussion:

1. In order to increase the scope and effectiveness of both programs and especially to take care of the needs of the late adolescent who gets lost between the two programs, there is a need for better articulation between special education and rehabilitation. Some means of fostering greater understanding and closer cooperation between the two groups, such as joint institutes, is necessary.

2. Concern was expressed for the child who is marginal in intelligence (too high for special education and too low for regular classroom) since he is a school problem and later may become a social problem. Also the adolescent who has been treated for emotional disorder and who now is too young to take part in vocational rehabilitation. States differ in their rehabilitation practice with some doing pre-vocational counseling in the high school, but the greater number reaching the student only after he leaves school. Definition of vocational rehabilitation in terms of employability enters in here. There was some discussion of the need to take the word "vocational" out of "vocational rehabilitation" so as to permit State agencies to work at all levels of need.

3. It was pointed out that the school is not meeting the needs of the slow learner and is probably hence contributing to his maladjustment. Workshops in the community may be partly an answer along with other rehabilitation activities. A revision of the legal definition of mental disturbance is needed to make rehabilitation efforts more reaching and to obviate the current gap in continuation of services.

4. Concerning rehabilitation of mental patients, after discharge from hospitals and treatment centers more specifically, differing kinds of approaches were brought up and described. The foster care program, the rehabilitation center, the half way house were discussed, and the need for cooperative effort on the part of the State mental health and rehabilitation facilities was emphasized. The programs should also offer their facilities to patients of private psychiatrists to be of the greatest service to the community.

5. Shortage of personnel was noted and a suggestion for redefinition of roles as a possible solution to the shortage was made.

6. Education of the community is needed in order that former mental patients may be accepted into productive employment.

7. Although the idea was expressed that much more could be done under existing laws if tradition and custom were broken or changed, the idea of legislation for Federal support of some of the above ideas was brought up and reacted to favorably by the group, particularly for post-hospital programs and for in-service training of various professions.

From these discussions, the group reached the following conclusions and recommendations regarding needs in the area of special education and rehabilitation of the mentally ill and emotionally disturbed:

SPECIAL EDUCATION ASPECTS

The experience of all of us is that emotionally disturbed children present a great problem to themselves, their teachers, their classmates, and society as a whole. Moreover, it is clear that these children can and should be identified early before their personal lives are deeply affected. We feel that the present status of know-how in the education of emotionally disturbed children is such that much can be done immediately if shortages of personnel can be met. Meanwhile, we should encourage pilot projects to explore intensively the most promising new approaches now emerging, promote a survey of the scope of the problem in terms of numbers of children nationwide who are in varying degrees disturbed and in need of help, and support basic research in child development and other relevant areas of behavioral science.

To accomplish these goals we propose the following "package" of four recommendations.

1. To bring immediate help to those working with emotionally disturbed children.

(a) Make allocations through State agencies of Federal funds (perhaps to be matched as under title V of the National Defense Education Act of 1958) for support of the services of school psychiatrists, school psychologists, school social workers, guidance counselors, and remedial teachers. These allocations should be usable to provide facilities, equipment, materials, and clerical assistance, as well as for salaries of professional personnel.

(b) Make grants to individuals and training institutions to provide training opportunities to help decrease the shortage of qualified—

- (1) School psychiatrists.
- (2) School psychologists.
- (3) School social workers.
- (4) Guidance counselors (particularly at the elementary school level).
- (5) Remedial specialists.

(c) Make grants to individuals and institutions to furnish background training to teachers and school administrators, who must continue to be the first line of "defense" against developing emotional difficulties. This should include not only direct grants for instruction in principles and practices of good mental health, but grants to train "professors of mental health in education" to provide this instruction.

2. To encourage pilot studies of new approaches.

(a) Grants to support citywide and/or countrywide demonstrations of new procedures on a scale sufficient to show what can be done when these procedures are applied intensively. (For example, a combination of day care centers and residential treatment in addition to special teachers in school and social work with whole families.)

(b) Grants to support smaller scale efforts to study and evaluate what specific new practices can mean if added to typical school arrangements.

(See appendix "A" for a description of one possible approach to problem.)

3. To determine the scope of need nationally in order to give better direction to the direct applications already recommended.

(a) Grants to a central agency, to work through States, to determine the numbers and proportions of children at each age level and type of community who need various types of help, such as—

- (1) Help by teachers.
- (2) Help within the school setting guided by professional specialists.
- (3) Day care at special centers.
- (4) Short-term residential treatment for observation and diagnosis.
- (5) Long-term residential treatment for reeducation.

4. To provide for development of new techniques and understanding.

(a) Grants in support of child development studies.

(b) Grants in support of studies of physiological and psychological factors.

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REHABILITATION ASPECTS

We recognize that the emotionally disturbed, if they are to make an adequate adjustment in society, must be returned to the community as employable persons. Since there are such great numbers of these people currently in the population and since the numbers are increasing rapidly with improved diagnostic treatment techniques which make it possible to return these people to the community instead of leaving them in mental institutions, the need for increased effort in the area of rehabilitation becomes even more acute.

This committee proposes recommendations in four broad areas to deal with these problems: (1) improved facilities, (2) training of personnel, (3) program to develop and expand employer acceptance, and (4) research.

Facilities

(a) We want to go on records as recommending extension and continuation of existing programs for establishment of evaluation and reeducation programs such as—

(1) Workshops for evaluation, job orientation, and work adjustment training.

(a) These facilities would be designed as an interim experience between hospital or clinic and a return to remunerative employment.

(2) Training centers in key population and/or geographic areas where psychotherapy, domiciliary care, vocational guidance and actual vocational training is provided.

(a) These facilities would be designed to provide treatment and training at the same time. This program would approximate the services now available in some physical medicine rehabilitation centers.

(3) Halfway Houses to assist hospitalized or other emotionally disturbed people who need such a service to bridge the gap between sickness and total adjustment to community living.

(a) We would suggest that this concept be broadened so as to provide more vocational orientation and not just social adjustment counseling.

(4) Intermediate facilities between hospital and local communities to which these disturbed people can return. (Such as foster homes or other facilities that later research may demonstrate as being desirable.)

2. Training of personnel

It is recognized that personnel shortages in the area of mental health may never be overcome. Therefore, it would seem desirable to improve and increase the skills of other professions so that they might contribute to this area of need. This might be done through—

(a) Outright Federal grants to States so as to provide training for persons to work with the emotionally disturbed.

(1) To provide upgrading of skills of Vocational Rehabilitation Counselors who are currently employed in vocational rehabilitation programs through additional graduate and internship training programs. (We suggest something like $\frac{3}{4}$ base salary plus tuition and supplies. Give them leaves of absence from their work so that they may take advantage of this training.)

(2) To train Employment Counselors, perhaps through some approach similar to that used for vocational rehabilitation counselors so as to increase their skill in placing the emotionally disturbed.

(3) To develop group therapy, group counseling and group work skills in ministers, school counselors, vocational rehabilitation counselors, social workers, welfare workers, psychologists, general duty nurses, public health nurses, parole and probation officers, and physicians, so that a minimum number of professionals in the community may reach a maximum number of emotionally disturbed people and augment services already given by psychiatrists.

(4) To provide orientation into the problems of the emotionally disturbed for personnel men in industry, police officers, union officials, community health and welfare organizations, jurists and the like.

(5) To provide upgrading of skills of personnel working in correctional schools so as to improve their skills in working with the disturbed inmates.

3. Program to develop and expand employer acceptance

(a) Give industry encouragement, through tax exemption or other financial incentive, to develop jobs in industry for persons who have a history of emotionally disturbance. This might include development of job orientation and adjustment programs for new employees who have a history of mental illness, clinical personnel to give supportive help to these new employees during early employment adjustment period, etc.

4. Research

Give grants to promote—

(a) Research into the rehabilitative counseling process to ascertain what IS good practice.

(b) Research to help develop new methods for the successful rehabilitation of the emotionally disturbed.

(c) Evaluation of jobs to determine the emotional stresses involved and personality characteristics essential for good job performance in various types of employment.

In no instance have we attempted to specify the costs involved in carrying out these programs. It is felt that such estimates can be made more adequately and realistically by a central body that has before it the recommendations emanating from the six regional conferences.

APPENDIX A

PROGRAMS FOR THE REEDUCATION OF DISTURBED CHILDREN

There is perhaps no segment of the mental health effort where facilities are more inadequate than in the care of the seriously disturbed child. There are a number of States in this region (as in other regions) where there is not a single bed for the residential care of the disturbed child. Children needing help are often put in an institution for the mentally deficient, mixed with psychotic adults, or put in a penal facility.

Society will not and should not long tolerate this situation. Yet there is no prospect of a solution within current conceptions of how facilities for disturbed children should be staffed. Manpower studies (also: Mental Health Manpower Trends) indicate that we are not going to have enough psychiatrists, psychologists, social workers, and nurses to man needed facilities in traditional patterns. We can solve the problem only by developing new conceptions.

In working with disturbed children it is possible that effectiveness depends more on the adult's personal attributes than on the extent of his training. It is believed that there are adults who are "naturals" in working with children and that these adults can be identified by careful selection. It is thus proposed that the manpower impasse be surmounted by developing around such people various programs for the care of disturbed children.

Specifically, it is proposed that we develop a matrix of services for disturbed children that will be staffed by carefully selected teachers who are given a brief period of initial special training followed by an in-service training program and who are then backed up in their daily work by consultant help from psychiatrists, social workers, nurses, pediatricians, psychologists, and other top level mental health personnel.

Two types of teachers would be needed: special educators for classroom work with the child and counselors who would serve as surrogate parents in residential facilities. In all facilities, school would keep. The school experience would be designed for remediation of learning deficiencies often seen in emotionally disturbed children, as well as for therapeutic benefit. In fact, it is anticipated that formal psychotherapy would be rarely used. Instead, every interaction of the adult with the child would be viewed as an opportunity for emotional re-education.

In many ways, the success of the program will depend on the ability of top level and expensive mental health specialists to reconceptualize their role in mental health programs. By working through other less extensively trained

people and thus making themselves more effective, the specialist can multiply his influence and thus justify his cost.

The teachers and counselors who are selected and trained for work with emotionally disturbed children would staff a wide range of services including special classes in public schools, day care programs, residential diagnostic centers (with psychiatrists, psychologists, and other specialists doing the diagnostic work), and longer term residential centers for the reeducation of disturbed children.

Mr. ELLIOTT. We thank you very much for your report.

Mr. GEER. The cochairmen of the neuromuscular and orthopedic groups could not be present. They were Charles S. Eskridge, director, division of special education, Texas Education Agency, in Austin; and Mr. Charles H. Warren, State director of the division of vocational rehabilitation, the department of public instruction, Raleigh, N.C.

Representing that group will be Dr. Perry Botwin, who is associate professor of special education at Texas Women's University in Denton, Tex.

**STATEMENT OF DR. PERRY BOTWIN, ASSOCIATE PROFESSOR,
SPECIAL EDUCATION, TEXAS WOMEN'S UNIVERSITY, DENTON,
TEX.**

Dr. BOTWIN. Mr. Chairman, distinguished members of the subcommittee, our concern is with those children and adults who, because of loss and/or defects of bone, muscle, joint or nerve, are unable to function properly for the purpose of education, work, and other general demands of living.

In a group broadly representative of the very professional and program interests in the related fields of special education and rehabilitation, there was emphatic agreement on the fact that in carrying out our responsibilities to these disabled persons, it is a case of too little, too late.

Quantitatively, we are serving only a small fraction of those who could profit materially by such services. Qualitatively, only the fortunate few get the broad scope of services that would help them achieve their highest potential.

In the matter of timing, all too few children or adults receive the educational and other rehabilitative services at this point of optimum readiness. Then the preventive and developmental values of such services as are rendered are largely discounted by this delay.

Most urgent needs: Our group felt that special education and rehabilitation should have parallel development. They are complementary services, each thriving best when supported by the strengths of the other two.

In our statement of most urgent needs, we recognize the mutuality of interests; namely, appropriate service to disabled children and adults.

With some sense of priority, the following needs are considered to be most urgent: First, program resources. The greatest single limiting factor in expanding services or in improving the effectiveness of present efforts is in the unavailability of professional personnel.

There is no professional field in which the supply even remotely approaches this level of need. Special education teachers, physical therapists, occupational therapists, nurses, physicians, rehabilitation

counselors, social workers, and psychologists must be recruited and given special training in large numbers if we are to approach this problem realistically.

Our Government, Federal, State, and local, must recognize this need and with imagination and a sense of urgency, create funds and resources for professional training of the needed specialists in the form of training grants, traineeships, and other forms of subsidy.

Concerning special facilities: While many of our moderately disabled can be educated and rehabilitated in facilities designed principally for the normal child, our experience is clear that those with serious, complex problems must have special facilities for diagnosis and treatment.

Special provision for the crippled child in the regular school, special classrooms or even special resident and day centers are indicated, as are rehabilitation centers, diagnostic facilities, and sheltered workshops for older youth and adults.

Insofar as possible, these facilities should be community based, but the need for regional provisions for special cases is well established. Such regional facilities would be especially appropriate to those who live in remote, rural areas. In this area, the Federal and State Governments should provide major assistance to the localities, not only in advice on standards and design, but with funds for construction and program establishment as well.

Funds for financing rehabilitation and education treatment are sorely needed. Agencies providing these services must adopt standards which virtually eliminate a long-term case in their need to reach a defensible number of persons. The economics of this situation clearly indicate that long-term training and rehabilitation are more in the public interest than is permanent long-term care.

Concerning program administration, even at our present level of limited service, we lose much of our effectiveness through lack of proper coordination and articulation of services. The multiplicity of public and private service agencies serving the disabled serves to magnify this problem.

Service program administrators of these Federal agencies should have an increased concern about the timing and continuance of services to the individual and to the prevention of wasteful duplication, overlapping, and competition.

Another factor, improved case finding, identification and statistics would do much to facilitate the realization of the above objectives. Administrators must make better provisions for these functions. The establishment of workable administrative mechanisms for joint planning and for liaison between the various services at Federal, State, and local levels remains a challenge to administration.

Concerning legislation to broaden program coverage, independent living rehabilitation legislation is strongly endorsed in principle with the present State-Federal rehabilitation program structure being the recommended avenue of administration.

Lowering the age limit in rehabilitation, to permit working seriously with lower teenage children in collaboration with public school personnel, and in special education and crippled children services, works to promote appropriate services to pre-school-age children.

There should be the revision of present allotment provisions concerning Federal grants-in-aid to States in vocational rehabilitation

to permit allotment to other States, the unused portion of a State's allotment and to remove the provisions of the present act that exerts negative effect on a State's effort toward program expansion.

Concerning research, it is believed that much improvement in the administration of present funds for research could be realized to prevent wasteful duplication and the support of weak, ill-conceived projects. A national clearinghouse of research activities and grants should be established to cover all Government-sponsored research in relating services to the disabled.

Also, medical research in the field of rehabilitation should be administered by the National Institutes of Health to insure better medical supervision and management.

There should be a greater expenditure for research and service demonstrations to facilitate the developments of new knowledge, new techniques, and new patterns for rendering service within the community.

In closing, I would like to state the committee expressed its appreciation for being asked to appear, and to make one statement: The time for planning and thinking has arrived. They feel strongly the time for action is now.

WORKSHOP REPORT ON ORTHOPEDIC AND NEURO-MUSCULAR DISABILITIES

Charles H. Warren, Cochairman
Charles E. Eskridge, Cochairman
Corbett Reedy, Recorder
Perry Botwin, Workshop Reporter to the Committee

Our concern is with those children and adults who because of loss and/or defects of bone, muscle, joint or nerve, are unable to function properly for the purpose of education, work and other general demands of living.

In a group broadly representative of the varied professional and program interests in the related fields of special education and rehabilitation, there was emphatic agreement on the fact that in carrying out our responsibilities to these disabled persons it's a case of "too little, too late." Quantitatively, we are serving only a small fraction of those who could profit materially by such services. Qualitatively, only the fortunate few get the broad scope of services that would help them achieve their highest potential. In the matter of timing, all too few children or adults receive the educational and other rehabilitation services at their point of optimum readiness. Then the preventive and developmental values of such services as are rendered are largely discounted by this delay.

Most urgent needs.—Our group feels that special education and rehabilitation should have parallel development. They are complimentary services, each thriving best when supported by the strengths of the other. In our statement of most urgent needs, we recognize the "Commonness" or mutuality of interest, namely—appropriate service to disabled children and adults.

With some sense of priority the following needs are considered to be most urgent:

A. Program resources

(1) The greatest single limiting factor in expanding services or in improving the effectiveness of present efforts is the unavailability of professional personnel. There is no professional field in which the supply even remotely approaches this level of need. Special education teachers, physical therapists and occupational therapists, nurses, physicians, rehabilitation counselors, social workers, psychologists, prosthetists, must be recruited and given special training in large numbers if we are to approach this problem realistically. Our government, Federal, State, and local, must recognize this need and with imagination and a sense of urgency create funds and resources for professional training of the needed specialists in the form of training grants, traineeships, and other forms of subsidy.

(2) Special Facilities—While many of our moderately disabled can be educated and rehabilitated in facilities designed principally for the normal child,

our experience is clear that those with serious complex problems must have special facilities for diagnosis and treatment. Special provision for the crippled child in the regular school, special classrooms, or even special resident and day centers are indicated, as are rehabilitation centers, diagnostic facilities, and sheltered workshops for older youths and adults. Insofar as possible, these facilities should be community based, but the need for regional provisions for special cases is well established. Such regional facilities would be especially appropriate to those who live in remote, rural areas. In this area, the Federal and State governments should provide major assistance to the localities, not only in advice on standards and design, but with funds for construction and program establishment as well.

(3) Funds for financing long term rehabilitation and educational treatment are sorely needed. Agencies now providing these services must adopt standards which virtually eliminate the long term case in their need to reach a defensible number of persons. The economics of the situation clearly indicate that long term training and rehabilitation are more in the public interest than is permanent, long term care.

B. Program administration

(1) Even at our present level of limited service, we lose much of our effectiveness through lack of proper coordination and articulation of services. The multiplicity of public and private service agencies serving the disabled serves to magnify this problem. Service program administrators of these Federal agencies should have increased concern about the timing and continuance of services to the individual and to the prevention of wasteful duplication, overlappings, and competition.

(2) Improved case finding, identification, and statistics would do much to facilitate the realization of the above objectives. Administrators must make better provisions for these functions.

(3) Establishment of workable administrative mechanisms for joint planning and for liaison between the various services at Federal, State, and local levels remain a challenge to administration.

C. Legislation

(1) To broaden program coverage.

(a) Independent living rehabilitation legislation is strongly endorsed in principle, with the present State-Federal rehabilitation program structure being the recommended avenue of administration.

(2) Lower the age limit—

(a) In rehabilitation to permit working seriously with lower teenage children in collaboration with public school personnel;

(b) In special education and crippled children's services, work to promote appropriate services to pre-school-age children.

(3) Revision of present allotment provisions governing Federal grants-in-aid to States in vocational rehabilitation to:

(a) Permit allotment to other States the unused portion of a State's allotment.

(b) To remove the provisions of the present act that exert negative effects on a State's effort toward program expansion.

D. Research

(1) It is believed that much improvement in the administration of present funds for research could be realized to prevent wasteful duplication and the support of weak, ill-conceived projects. A national clearinghouse of research activities and grants should be established to cover all Government sponsored research in relation to services to the disabled.

(2) Medical research in the field of rehabilitation should be administered by NIH to insure better medical supervision and management.

(3) A greater expenditure for research and service demonstrations to facilitate the development of new knowledge, new techniques, and new patterns for rendering services within the community.

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Mr. ELLIOTT. Thank you very much, Dr. Botwin.

Mr. GEER. Our last section of the day will be the section on gifted children. Before I introduce the report of that section, I would like to say again that the people in the workshop appreciated the opportunity to get together, and I am sure that if they were all here and could see you folks laboring so patiently and diligently, and listening to so much for so long, that they would certainly appreciate their representatives.

Our last speaker will be Dr. Virgil Ward, who was chairman of the section on the gifted, carrying the load by himself, and he now will report to us on the findings of that group.

Dr. Ward is from the University of Virginia, at Charlottesville, and has been a consultant on the boards of various projects concerning gifted children and will soon begin to direct a yearlong project pertaining to the State department of education personnel concerning the education of the gifted.

STATEMENT OF DR. VIRGIL WARD, COLLEGE OF EDUCATION, UNIVERSITY OF VIRGINIA

Dr. WARD. Mr. Chairman, Mrs. Green, gentlemen of the subcommittee, I, too, would like to express the appreciation of the workshop group on the gifted for this opportunity to present some of our deliberations to you this afternoon.

It has been remarked that the gifted child who is generally conceded to be the most educable child is quite often found to be the most retarded child in terms of grade placement in the American school. I am sure that the committee would accept this opening remark of

mine in the good spirit that it is intended, if I suggest that we find ourselves here this afternoon at the tail end of these deliberations in the historic position that the gifted child has been in terms of consideration by American society.

We are quite happy, indeed, I might say, to find a changing and a changed climate of opinion in this regard, which will make your work in our behalf much easier, and it certainly makes our concerns more readily worked with.

I should like to say just a word for the group concerning the logic of special education for the gifted. It is not that you subcommittee members would at all need to have this logic presented, but that many of the people with whom you must discuss the problem will need a presentation of the logic.

We consider it to be exactly the same as it is for children who are mentally retarded, namely, that at some point on either end of the scale of intelligence there arrives a position in which the normal grade school experience for children must be adapted to meet the differential abilities represented by children who fall at the extremes of the scale. This is a well understood concept and there has been much admirable and worthwhile activity in the direction of meeting the special needs of children who fall at the lower end of the intelligence continuum and we feel that it is for exactly the same logic that we need a study, a differentiation of educational experience, to parallel the superior capacities, abilities, and particular needs of the child who falls at the upper extreme of the intelligence continuum.

An analogy which I found useful in this connection comes from athletics, suggesting that the good runner will perhaps win the race or track meet even though the track upon which he is running is not an especially well prepared one. But I think we would all concede that he is scarcely likely to set a record or to do his best running on a poor track.

We suggest that it is possible for us to devise a better track upon which the gifted child may run, by way of an educational curriculum. We would suggest also that in this connection of arriving at differential experiences for differentially endowed children, that this concept, far from being opposed to the democratic ideal, is really quite necessary to it.

We feel that we are in a particular position in the field of special education. We are most happy, of course, to be included in this grouping. But on the other hand, by virtue of this historical position which we have occupied, in which the attention of the Nation has centered first upon the handicapped child, we find ourselves in a position not simply of being shorthanded in terms of personnel, or shorthanded in terms of a developed science, but almost at the zero position in terms of personnel and concepts that are peculiarly and particularly adapted to the needs of the gifted child.

We have enough evidence to indicate quite clearly that there is a need here, but several of our particular recommendations will be contingent upon the fact that we face honestly, as professionals in this area, that we do not have a developed body of science or a developed body of technology or practices which support the clearly recognized need for special education of the gifted child.

I would like to offer for your consideration four major areas of need, isolated by the workshop group within the past 2 days, and

these will be presented only in a very brief résumé by virtue of the fact that the full report will follow.

We feel first that there is a vast need for pulling together such bits of science, research, knowledge, reliable opinion, as have accumulated through the years in this particular field. We are more diversely spread, we are more heterogeneous in our knowledge in this area unquestionably, from the very definition of what a gifted child is, than are some of the other areas with a well established history and a great body of practices specifically in those given areas.

So we would suggest first that a very admirable expenditure of funds supplied from the Federal level, most realistically, would be a series of conferences, similar to the Utah conferences on creativity which were established by the National Science Foundation in the years 1955, 1957, and 1959, to bring together a relatively small group of highly qualified persons for a rather lengthy period, running more than 3 or 4 days, into a couple of weeks or more, to blend their minds, their knowledge, together to clarify and codify the real positions that exist in terms of present knowledge.

We feel that only through such a medium can we establish working definitions and conceptions which will furnish guidelines for the continuing research, the search for knowledge that will go on in this area. We face honestly the fact that we are unable now to tell how great are our needs in many specifics because those specifics have not yet been isolated and identified at the conceptual level.

Secondly, we suggest that there is a near vacuum at the level of leadership training. Again this, we think, is a tribute to the default of long experience with supportive community attitudes and financial undergirding. We have few persons, not enough to put in terms of percentages, but few persons on an absolute scale in State departments of education throughout the Nation who are qualified to speak specifically of the particular needs of the gifted child, even at the college level, the college and university level, where you will find quite well trained people to deal with the various levels of handicap, various areas of special need of other categories of exceptional children.

We find a small handful of people who are trained to speak reliably and authoritatively with respect to the particular needs of gifted children. Of course, it would go without saying that a near vacuum at those two levels would, of course, leave us with a very near vacuum, again, of classroom teachers who are specifically trained to deal adequately with such children and also vocational rehabilitation personnel.

I think we might take a reading from the fact that we were unable to locate readily a single vocational rehabilitation person to sit with our group in these deliberations to indicate to you the void of concrete, particular practices in the area of vocational rehabilitation with respect to the gifted child.

Third, we suggest that predicated upon the idea, the faith, that there is a better educational curriculum than we have yet devised for the gifted child, we honestly admit that we do not know exactly the form, the content, the organization, of such curriculum, and we suggest this as a third major area of need.

We are concerned that legislation existent presently provides for a rather radical reconception and reformulation of certain subject mat-

ter areas, specifically natural sciences, foreign languages, but that there are other subject matter areas equally as vital to the citizenship-education of the gifted child, to the liberal education of the citizen, which are equally as important in terms of their being reconceptualized for the advanced intellectual perceptions of the gifted child.

Fourthly and finally, in terms of the immediate needs that we were able to carve out is our old friend that I have scarcely heard not mentioned by any group this afternoon—research. Out of some 13 details that we isolated here for urgent need for research, I should like to suggest only 1, leaving the others for your attention in the report.

We have a very fine, one of the finest and most exemplary studies in American psychology, accomplished by Louis Turmond, in the interest of the gifted child, his genetic studies of genius, in which he followed some 1,000 children from the State of California for a period of 35 years, beginning at age 10, and the latest report concerned them at approximately age 45.

No studies since the time that Turmond has started his reports have served to refute any of his major findings. Therefore, we have a backlog of quite reliable scientific information concerning the nature, the learning characteristics and processes of these children, and we suggest to you as a group that we need a similarly well conceived, imaginative body of research on the curriculum content and organization conceived over a longitudinal period that parallels these fine abilities of the children.

Mr. Chairman, I brought my watch with me, but I am afraid I failed to look at it. I have concluding remarks. Could I have one moment on those?

Mr. ELLIOTT. Yes.

Dr. WARD. As we began to speak to you on the logic of special education for the gifted, I should like to close with a suggestion toward the promise, the social gains that stand to result from special education for the gifted youth.

Dr. Thorndike, some years ago, raised a most imaginative and provocative question pertaining to this point. He asked what could the world afford to pay for the cure to cancer some 10 years earlier than it will otherwise come to be?

We would suggest to you not at all with a slight degree of derogation of the admirable efforts that have been put into the effort of the mentally retarded child, we suggest to you and urge you to apply just this logic: that if we consider that the special education of the mentally retarded will bring such a child up to a level where he may be self-subsistent and make a minimal contribution to society beyond self-subsistence, that on the other hand, special, improved, compacted, excellent education for the gifted child stands fair to yield to society a return more nearly in the character of 100 to 1, 1,000 to 1, if indeed not 10,000 to 1 upon the investment.

This is the bright promise of special education for the gifted. By way of figures, we suggest that even if you start with the top 1 percent of the intelligence scale and take the figure of 37 million school children in America, that would leave 370,000 children who are capable of taking an infinitely more difficult and improved education than they are presently engaging in.

I thank you and the committee for the privilege of being heard.

Mr. ELLIOTT. Thank you, Dr. Ward. Where are you from, Doctor?

Dr. WARD. The University of Virginia.

Mr. ELLIOTT. Thank you very much. You have given us a stimulating challenge.

WORKSHOP REPORT ON THE GIFTED

Chairman: Dr. Virgil S. Ward, University of Virginia

Recorder: Mrs. Carolyn Fleming, DeKalb County (Georgia) Public Schools

- I. Purpose of the Study.
- II. Rationale of Special Education for the Gifted.
- III. Nature of the Need.
 - A. To Establish a "Science" of Special Education for the Gifted.
 - B. To Train Personnel in All Categories.
 - C. To Advance Knowledge of the Nature of Giftedness.
 - D. To Develop Multiple Curricula.
 - E. To Discover Appropriate Patterns of Educational Organization.
- IV. Implementation of Aid Through Federal Resources.

I. PURPOSE OF THE STUDY

- A. To determine adequacy of existing Federal legislation in meeting needs.
- B. To identify needs not being met.
- C. To recommend useful additional Federal support.

II. RATIONALE OF SPECIAL EDUCATION FOR THE GIFTED

The logic of special education for the gifted.—The members of this section consider that special educational needs exist for gifted children by virtue of exactly the same reason that they are recognized for other types of exceptionality. Differential natural endowments and developed characteristics, in the case of the gifted these being fortunate in nature, are such that educational processes which satisfactorily develop persons within the usual range of behavioral potential, fail exactly and fully to bring to fruition exceptional learning capacities. Educational experiences which parallel and satisfy those deviant qualities through which persons of superior intelligence and aptitude are identified, may be thought of as unique to the gifted. It is the quest of special education to develop both reliable means for detecting giftedness of all kinds, and for improving educational content and methods for the optimum development of persons so endowed.

The justification of special education for the gifted.—The efforts to meet satisfactorily the differential needs of bright and talented youth are justifiable on two principal counts. First, the democratic social ideology rests upon opportunity for the individual, whatever his nature and needs, to realize himself as a person. The fullest development of persons of extraordinary endowment demands that special endeavors be made to seek out, to satisfy, the personal needs dictated by the nature of their individual capacities.

Second, society gains from the effort. If education affects behavior at all, serving to develop the individual's potential for performing productive services, the search for improved techniques through which to develop in a superior manner the superior endowments of the gifted, promises magnified benefits to society in return for the investment. Even a slight improvement in the ability and productivity of a person of great capacity for thought, or learning, or creativity, yields disproportionately more than does equivalent improvement in the education or training of persons of moderate endowment. Gifted children typically become productive adults, advancing human culture on all fronts, including the sciences, the progressions, the arts, and social and governmental services. To discover such persons early in the school years, to improve upon their school experience, and to compact their formal education into a shorter number of years, therefore, promises all the benefits to mankind represented collectively by continuing advances in the arts and technologies that comprise human culture. E. L. Thorndike's early question: What could the world afford to pay for the cure for cancer ten years earlier than it will otherwise come to be? is a realistic charge to responsible officials and educators on the contemporary scene.

Differences in history and background of this effort.—The American nation has arrived late at a clear realization of the significance of special education

for persons of superior ability. In contrast to the field of mental retardation, there is a paucity of organized lay and professional promotion of the cause of the gifted, there is an incomparably smaller body of research and study devoted to learning activities and the development of educational materials, and a near dearth of tested administrative practices in schools which modify regular procedures better to accommodate the gifted. While there have been single scholars here and there, notably Lewis M. Terman and Leta S. Stollingsworth, who have envisioned clearly the significance of special education for the gifted, public opinion as a whole has not until the present decade supported the various fronts upon which advancement of this cause must now proceed. It is from this fact of differences in the history of the movement of education for the gifted in America which stems several of the recommendations that occur subsequently in this report. It is a happy turn of affairs, indeed, that the public mind today has moved toward demanding the very special attention for the gifted youngster, which would have been considered unwise and undemocratic but a scant number of years ago.

Preamble to the recommendations.—The study group based its deliberations upon the following articles of faith:

1. That there is a body of definable characteristics which distinguish individuals such that they can be designated by some term like "gifted," and that these differentiating characteristics demand differential education. (For purposes of these deliberations an arbitrary delineation setting off the top three percent of persons on scales of either general intelligence or specific aptitudes was accepted. It was felt that the more extremely deviant the group, the more justifiable their inclusion in the field of special education.)

2. That pointed and sustained effort, supported by facilities and resources, can discover patterns of educational organization, curricular content, and teaching methods which will serve better to develop the gifted than do the curricula which serve the generality of children and youth.

3. That a search for successful education for the gifted no less intense and comprehensive than that for other types of exceptional children is not opposed to the democratic concept, but rather essential to it.

III. NATURE OF THE NEED

A. *To establish a "science" of special education for the gifted.*—Such knowledge as has been accumulated concerning the nature of giftedness and its proper development through education has been accomplished so diversely, and under such varying frames of reference that a need exists to pull together what exists into an orderly collection of facts and principles that may be said to comprise a "science." Concepts should be clarified, definitions distinguished and contradictions therein resolved, and miscellaneous terminology reduced to economical and functional classifications. Such concentration at the level of theory promises to yield guidelines for future research and educational practice, such that duplication may be minimized, trivia abhorred, and the repetition of unfruitful efforts avoided. Even reliable quantitative estimates of needed personnel, financial support, facilities and equipment must await such clarification of concepts and classification of existing knowledge.

Part of such a "science" would be the particularization of objectives for special education of the gifted, assuming that particular objectives do pertain. And, so the members of the group thought, the concepts of rehabilitation, largely undeveloped with respect to the gifted, needs to be imaginatively explored as a means of restoring wasted human resource in especially promising areas.

To meet these needs:

1. Conferences of selected, qualified scholars, similar to the National Science Foundation Conferences on Creativity (the Utah Conferences of 1955, 1957, and 1959), running for a sufficient length of time to permit reflection and deliberate thought.

2. Grants in support of critical reviews, analyses, and attempts at syntheses of thought leading toward comprehensive theory.

3. Dissemination of reports of such progressive advances in theory and science by appropriate governmental agencies in manner similar to distribution of health literature, etc.

4. Systematic endeavors to establish techniques and procedures for the utilization of emerging machine processes for codifying and processing information and data for research analysis. Modern data processing methods and machinery permit large-scale investigations impossible, if not inconceivable, but a few years back.

B. To train personnel in all categories.—Whereas those especially concerned with other areas of exceptionality among children speak of personnel “shortages,” the field of the gifted manifests a near vacuum of persons specifically prepared in related professional competencies. College and university teachers, State department of education officials, school psychologists and counselors, curriculum supervisors, special education teachers, and vocational rehabilitation personnel—in scarcely any of these categories are specific concerns for the gifted explicitly recognized in professional training and professional practice. The contrast with the degree of emphasis among all such specialists on the problems of the retarded and handicapped serves but to suggest how much remains to be done for the fortunately endowed.

To meet these needs:

1. Grants for leaves of absence on the part of college and university personnel to study successful programs of education for the gifted, and theory that might lead to still more appropriate practices.

2. Institutes, long term and short term, similar to guidance institutes under the National Defense Education Act, geared to the applications characteristic of each level of personnel noted above.

3. Scholarships for teachers in academic year institutes, as well as encouragement of this emphasis in undergraduate teacher training programs. Question: What would be the effects of 250 leaves of absence for college personnel, of 1 academic year institute in each state, and of 1,000 summer scholarships for teachers, yearly over a period of 5 years time, in the massive upgrading of American education to meet this critical area of neglect?

C. To advance knowledge of nature of giftedness.—The basic characteristics of intellectually superior performance are reasonably well known. Terman's major researches have been paralleled by dozens of minor studies in which measured intelligence was the experimental factor. And the instruments for the detection of intellectual superiority even in early childhood are far and above the most reliable psychological instruments which have been devised. On the other hand, almost as incomplete as this body of facts is full, are similar facts and similar instruments for detecting specific forms of behavioral efficiency which we call aptitudes or talents. We need knowledge of the origin of such singular traits, of the manner in which they develop through childhood, and of modes of schooling which support and contribute to their optimum fulfillment.

Also similarly void is an extracting knowledge of the emotional and motivational substructures which lie imbedded within the personality of the gifted individual, and which make the difference between whether his general or specific intellectual functions shall become suitably operative. What are the differential dynamics among people who are constructive, productive, and creative, as distinct from passively efficient and merely adjustive. What causes one gifted person to achieve commensurately with his ability, and another to assume no more responsibility in life, or to produce no more than persons with modest biological endowment? And what is possible by way of rehabilitation of persons whose early careers run counter to expectation, as their adult years unfold? These are questions vital to the wisest utilization of human talent as a natural resource.

To meet these needs:

1. Generous continuing support of scientific research in the manners acknowledged and referred to in section IV of this report.

D. To develop multiple curriculums.—Paralleling in importance the need to know much more fully the nature of gifted persons, is the need to know what kinds of experience—integrated at what age levels, and administered in what particular contexts—will serve most appropriately to foster and develop the priceless biological deposits of superior intelligence and aptitude. The question has been aptly raised, What would we do with a young Robert Frost if we were in fact able to identify him surely at the age of 10? As observed previously, if education in general is good for the generality of persons, then it must be possible (and special educators believe it is) to discover patterns of special education for the gifted which differ, and which improve upon the common curriculum.

In particular, there appears to be a limited concept of the range of significant knowledge enjoying support in existing legislation. If it is useful to know how persons of foreign extraction speak, is it not even more basic to know the cultures out of which their minds, their funded behavior emerges? And if it is important

that research proceed in physical science, is it not even more important that there be advances in knowledge of the desires and impulses which lead man to apply technological skills and machinery to certain uses over others? The participants in this section of the workshop believe that both the humanities and the social sciences should be covered as adequately in specific legislation supporting research as are mathematics, the natural sciences, and foreign languages.

Beyond this, it appears strikingly true that the school curriculum has changed its character during the past half century in no manner at all parallel to the magnitude of change in social problems and scientific advances. Hence, there is a need to restudy school experience from imaginative and fresh perspectives, with an attempt to arrive at what Walter Lippmann has termed a necessary "breakthrough" in educational processes.

There will be a need for increased support for the purchase and maintenance of facilities, equipment, and material, if educational techniques are to reflect properly the differences between the complicated technological and social world of yesterday and today.

To meet these needs:

1. Grants for curriculum reformulation in areas other than mathematics and natural science. As mathematicians are developing exciting new approaches toward mathematics education, so there needs to be a similar inquiry into the humanities and the social sciences. The National Science Foundation, with all of its subordinate activities, could and should be paralleled in other academic disciplines.

2. Support through State departments of education and college, and university departments for action research on various types of reformed curricula, instructional methods, etc.

3. Aid in the purchase of expensive equipment for the schools in a manner somewhat commensurate with the repeated gestures toward aid in school building construction.

E. *To discover appropriate patterns of educational organization.*—The impact of education upon human development is of a whole cloth; pieces and threads, no matter how strong or how beautiful, do not comprise useful or pleasing fabrics until woven into a whole. So it is that optimally effective combinations of educational practices must be sought for, patterns of overall school organization that combine in various forms special classes, and special instructional materials and methods—and these applied at different age-grade levels, and for different periods of time—if the total and enduring effects of education in bringing to fruition the talents of exceptional persons are to be reliably known. Do we have the best entry and terminal points for schooling the bright, or would successive returns to advanced institutes for thought and research during the mature years of adulthood be profitable in conducting toward the highest development and utilization of the minds of men and women of great ability? In every level of attack upon the problem of educating the gifted, the manner is fragmentary and piecemeal: in research, in curriculum revision, and in administrative adaptations of the school program.

And very little is known beyond surface level generalities about the nature of the teaching personality which is most conducive to proper development among creative and productive young people. Do such children need "supportive" persons around them, or those who firmly expect independence? Is meticulous explanation, or inspiration and challenge the better communicative climate? Should there be differing types of teaching personalities at the primary, intermediate, and secondary levels of school? These and many other problems remain with respect to the personality of the teacher as an organic part of the total educative influence.

To meet these needs:

1. Support for well-conceived, longitudinal experiments covering one to five decades, under institutional auspices, in pilot centers of varying designs: again, combinations of special classes, special schools, reorganized school terms, early admission and early graduation, etc. Only through longitudinal studies can the full impact of educational provisions upon the person in his total lifespan become known.

IV. IMPLEMENTATION OF AID THROUGH FEDERAL RESOURCES

The participants in the section on the gifted believe that there is much to be commended in present Federal aids to special education and rehabilitation.

Many sound features characterize the administrative machinery through which these aids are channeled, as in the regular functioning of the U.S. Office of Education, the National Defense Education Act, the National Science Foundation programs, the Cooperative Research Program, and the other forms of aid at higher or lower categorical levels. The incorporation of professional advisory councils to weigh the value of proposed projects is viewed as a desirable feature in several respects. Expressed with the strength of an article of faith was the desirability that all Federal aid should be exercised with freedom in usage at the State and local levels. It was expressed as a matter of concern, in fact, that the States had shown possibly too little vigor in taking advantage of such support as is presently available in diverse forms, and too little imagination in applying these resources to their most vital needs.

There was general recognition that waste through duplication of effort was inevitable in piecemeal legislation; at the same time, however, no particular advantages were seen to the needs of the gifted in single acts designated therefor, which could not be obtained through clearly delineated, permissive uses in omnibus bills geared to the advancement of all types of exceptionality among children and improperly functioning adults.

On the more adverse side, it was noted by the group that no specific Federal legislation in the interest of the gifted was actually in operation, similar to those provisions well established for other areas of special education. The National Defense Education Act, intended in the majority to perform this function, was worded in such a way that general uses were allowable, and accordingly general uses have been made. Also, it was regretted that the coverage of the NDEA was such as to exclude the elementary school levels, and to place emphasis upon selective subject matter as noted herein.

A variety of methods of Federal support appeared appropriate to this group of professionals, many of which have been indicated in the preceding statements of need: Research grants, traineeships, top-level conferences, complete facilitation of higher education for those able to profit from it, funds for facilities and equipment, etc. The importance of varied forms of support was recognized, and of varied forms of research, such as experimental and action. By virtue of the peculiar state of incomplete development as a science which characterizes special education and rehabilitation for the gifted, especial usefulness of deliberative efforts of qualified scholars bent toward the development of comprehensive theories, and the devisement of productive experimental methodologies was emphasized.

And, finally, it was considered especially important from a long-range point of view that the most promising methods now available for data processing and the codification of knowledge for dissemination and further research, replace the near obsolescent procedures upon which science and scholarship are now dependent. This need was foreseen as becoming increasingly important.

Even in the post-War II period, 1945-60, characterized by such vital international realignments and shifts in status and power, and by near-unbelievable scientific and technological changes, there have been but slow forward movements in special education for the gifted. Scattered, unsystematic, often superficial and usually inadequate gestures have prevailed. America, even in these critical times has been hampered by a public mentality that reluctantly tolerated, and deliberately withheld sanction for special educational efforts in behalf of persons incontestably better prepared to return in social gains more than those who received the more generous support in a rightful but narrow interpretation of the democratic principle of equalitarianism. The Subcommittee on Special Education and Rehabilitation is to be commended for including in its efforts, now that the climate of opinion has changed, generous and imaginative support for investment in the top strata of human abilities.

MR. ELLIOTT. We have one other witness, Mr. Otto H. Nebrig, from Decatur, Ala.

STATEMENT OF OTTO H. NEBRIG, INTERESTED PARENT,
DECATUR, ALA.

Mr. NEBRIG. We have heard quite a few good speeches here today. I have been here all day and I haven't heard any from a parent. I am a father of a mentally retarded child. He is 6 years old. He cannot talk yet.

The doctors tell us he will. I have carried him to Birmingham and to Nashville. We have just recently started a unit in Decatur for the mentally retarded, trying to get something done. Mrs. Beasley, with the State board, helped us get it started.

However, I am not speaking for that body. In fact, I came down here without any intention of saying anything, but just to listen.

I have three normal children, one 25, one 24, and one 12. Then I have this child who is 6. The three older children are getting their education from the public schools in the city of Decatur. I think the other child should have an equal opportunity. I do not think, in other words, any additional expense other than what the child is normally entitled to expect would be had.

I think the parents would be willing to kick in. But the main thing I am interested in is a center for the evaluation of these children so we will know what they can do, what we can expect, how much of an education they can absorb, if they are educable or whether they are trainable or what can be expected. That is one thing I know we need.

Then if the child can be educated, it ought to be afforded some place in the public schools or some facility where it can have whatever education it can absorb, or if it is not educable, if it is trainable, then a workshop should be available where it can get the training it can take for what it is best fitted for.

But the main thing is the center they are trying to get set up in Birmingham now, to evaluate these children so we can tell what to expect and what they can do. Of course, our boy, he is 6 years old and he is healthy, except mentally. He cannot talk. The doctors tell us he will talk, but I do not know when and they do not know when. We love him and we are proud of him. We are not ashamed of him.

Any questions of this committee I would like to answer.

Mr. ELLIOTT. Mr. Nebrig, you brought us a very down-to-earth and practical approach to the problem and have made a contribution to our hearing. We appreciate it very much.

Mr. NEBRIG. Thank you.

(The following material was submitted for the record:)

TESTIMONY OF DR. T. MUNFORD BOYD, PROFESSOR OF LAW, UNIVERSITY OF VIRGINIA
LAW SCHOOL

My name is Munford Boyd. I am a member of the board of directors of the National Federation of the Blind and professor of law at the University of Virginia. I am, of course, familiar with the activities of the National Federation of the Blind and of the 46 statewide organizations of blind men and women of which it is composed. I wish to discuss briefly two needs or problems which are important to the Southern States, but no less to the Nation as a whole.

THE NEED FOR CONSULTATION

On behalf of the organized blind, I wish to commend this committee for the extensive and highly productive consultations which it is presently conducting through the utilization of the workshop approach with the blind and other groups of our handicapped population. Not only the unprecedented range and depth of these regional conferences, but the serious concern which they reflect on the part of Congress for the views and interests of the citizen groups most directly affected, constitute a model of the democratic principle of consultation as it finds expression in the political process.

With your permission, I should like to address my brief remarks to that same principle of consultation—which has been aptly defined as “the right to be heard.” I need not waste the valuable time of this committee in unnecessary explanations, for I know of no other institution in our public life which so clearly and consistently recognizes the importance of consultation as the committee system of Congress itself, with its regularized public hearings on matters of pending legislation in which all interested citizens may give expression to their views in full confidence that they will be respectfully heard.

Unfortunately, not all public agencies engaged in executing the laws and administering the policies laid down by Congress have displayed an equal awareness of this vital principle of government. Indeed, it is in the particular area of policy administration with which this committee is directly concerned that the procedures of consultation with affected citizen groups are perhaps least operative and least effective.

It goes without saying that the very meaning of the principle of consultation, as embodied in both the legislative and administrative branches of government, is that individuals and groups affected by public programs have the right to be heard in the formulation and execution of those programs. Thus, it is not only our legislators who are to be regarded as representatives of the people, although their democratic election makes them preeminent in that respect. Representative government extends as well to the executive and administrative agencies responsible for the performance of the programs approved by Congress. It is especially within the field of public administration that the representative device of consultation finds its most direct and forceful application, just as it is here that problems of democratic responsibility and control are most evident.

The multiple values of consultation in the administrative process have, of course, long been recognized by the Federal Government. For a typical example, the 1941 report of the Attorney General's Committee on Administrative Procedure (77th Cong., 1st sess., Doc. No. 8) contains a detailed account of the development and function of consultative practices: “As economic and other groups in the community became organized and vocal,” the report stated, “and as legislation affecting them came more and more into existence, administrators, in contact with those upon whom their authority bore, turned to them for information and their point of view. Participation by these groups in the rulemaking process is essential in order to permit administrative agencies to inform themselves and to afford adequate safeguards to private interests.” It would require more time than I have at my disposal to itemize either the number of Federal agencies which institutionalized the principle of consultation or the wide variety of methods which they have employed for this purpose. It is perhaps sufficient to observe that professional and scholarly authorities in the fields of law and public administration are unanimously agreed that there are few features of democratic government more nearly indispensable than that of active participation by interested citizen groups through systematic procedures of consultation. By way of illustration, I might cite the conclusion of one such authority, Prof. Avery Leiserson, that “it is perfectly clear that in the sense of the right to be heard, to be consulted, and to be informed in advance of the tentative basis of emerging policy declaration, group participation is a fundamental feature of democratic legislation and administration.”

All this may seem to be only a demonstration of the obvious. Unfortunately, in the administration of public programs of vocational rehabilitation (including sheltered workshops) as well as those of public assistance, the principle of consultation has in the past been honored more often in the breach than in the observance. Particularly with reference to programs directly addressed to our blind population, the need for the clients to be heard and consulted has been for the most part ignored by administrators both of Federal agencies and of State agencies participating in the use of Federal funds. In fact, spokesmen for some

agencies for the blind have gone so far as to deny, not only the need and desirability of such consultation on the part of blind clients, but even their right as citizens to be consulted. Thus, a national association of agency workers for the blind has declared publicly that any legislation aimed at protecting the consultative right of blind groups "is not only unnecessary and unjustified but * * * embodies a completely unsound and retrogressive concept of the responsibilities and privileges of blind persons as citizens."

In view of this and similar denials of the right of our blind people to be heard on the policies governing their welfare, it is pertinent to note that only if blind persons are regarded as less than citizens and less even than alien residents—only if they are to be classified together with convicted criminals and the mentally ill—can such a constitutional deprivation be upheld. For the right of all others to be heard and consulted on matters affecting them is embodied no less plainly within the guarantees of the first amendment than their right to speak upon public issues. The right of free speech has always been recognized as carrying with it the corollary right to be heard: it is for this reason that the first amendment explicitly protects not only the freedom of speech and assembly but the freedom of petition as well.

However, even where the constitutional right of consultation is granted to the blind, there are those who assert that they are "professionally unqualified" to exercise that right. The most frequent argument against consultation with organizations of the blind is that such groups are unprofessional and, hence, incompetent to make a meaningful contribution to the development of public policy. Aside from the simple untruth of this contention, there can be little doubt that the original source of the attitude which it expresses is the crumbling tradition of custodialism and dependency in which the blind have been held for centuries by charitable institutions entrusted with their welfare. Nor is it only private institutions and agencies which continue to maintain this view; public officials at the State and National levels are still largely recruited from such institutions and tend to share their assumptions concerning the capacities of their blind clients. Given the historic relationship between public welfare agencies and their private (or semiprivate) counterparts, it is scarcely surprising that consultative procedures between the two should today be as close and highly developed as they are casual and underdeveloped with respect to organizations of the blind themselves.

It is a simple matter to demonstrate the concrete values of direct consultation by and with the blind in the conduct of their public programs. There are three distinct areas of governmental policy to which such consultation is especially applicable, each of them administered under the authority of the Department of Health, Education, and Welfare. The three are: (1) The public assistance program for the blind (42 U.S.C.A. 1201-1206); (2) the vocational rehabilitation programs (29 U.S.C.A. 31-42); and (3) the vending stand program (20 U.S.C.A. 107-107f).

In public assistance, the potential contribution to be made by the blind through their own organizations has been greatly augmented by the new and constructive approach which since 1956 has concentrated upon the objective of assisting blind persons "to attain the maximum economic and personal independence of which they are capable." The significance of this feature of the blind aid program cannot be overemphasized; every force that is capable of supporting the rehabilitative goals of self-support and self-care must now be brought to bear upon its administration. Among the most effective of such forces are, of course, the voluntary associations of blind people themselves, who for decades have been dedicated to the achievements of such a reorientation of the philosophy and objectives of public aid. If the new spirit of the laws is to find genuine expression in practice, the principle of consultation with the self-organized blind must be given full scope and recognition.

In the programs of vocational rehabilitation and employment, including those of workshops and vending stands, the broad goal of restoring the productive powers of blind men and women—together with the specific tasks of training, counseling, guidance, and placement—can obviously be facilitated through the active participation of organizations of the blind themselves. Without such consultation, indeed, there is little to counterbalance the regressive tendency of program administrators to limit the preparation of blind clients to those routine and stereotyped occupational channels which represent the path of least resistance. The modern objective of full integration of the blind within society on a basis of normality and essential equality is not likely to reach fruition until the blind themselves are permitted to contribute their accumulated experience

and insight through systematic participation—which is to say, through regularly established methods of consultation by officials with representatives of the organized blind.

Although the custodial attitudes of condescension and contempt toward the blind still operate on various levels of administration to hamper effective consultation on a basis of mutual confidence and trust, I do not wish to give the impression that such attitudes are universal. On the contrary, in many States the close working relationships between agency administrators and organizations of the blind are highly productive and rewarding to both sides. It is no coincidence that these are also the States in which public programs of aid and rehabilitation for the blind are most enlightened and successful. No one who has watched, as I have, the development of these State programs through harmonious cooperation between the organized blind and their agencies of government can continue to doubt the vital importance of the principal of consultation or to question the right of blind men and women to speak for themselves and to be heard in the public conduct of their affairs.

INDEPENDENT-LIVING REHABILITATION

The objective which is sought by the enactment of independent-living legislation is extremely worthwhile; however, if legislation of the type proposed—especially legislation of the type now pending before this committee (H.R. 3465) should be enacted without proper safeguards, the disadvantages of such legislation would probably outweigh any gains which might be realized from it. For more than a year the controversy concerning the independent-living bill has raged throughout the country. Blind persons have more to gain or lose by the enactment of this legislation than perhaps almost any other group. Independent-living legislation as a part of the Vocational Rehabilitation Act would not only affect the unemployable blind person, it would affect almost every vocational rehabilitation client in one way or another. Many services to the blind are not now considered as coming within the scope of vocational rehabilitation. This means that home teachers, for example, must be paid entirely from State funds, except in those instances where the home teacher works with a vocational rehabilitation client. The time spent in such work can be charged against vocational rehabilitation case service funds, but the redtape and recordkeeping involved are so cumbersome that many States do not take the trouble to claim the Federal reimbursement. The result is that salaries and standards in the field of home teaching are far below those in rehabilitation. It is not difficult to see why this is so. If a State gets two Federal dollars for every State dollar that it puts into the salary of a vocational rehabilitation counselor, it can pay that counselor \$5,100 for a total investment of \$1,700 of State money. Thus, it will cost the State more to hire a home teacher at \$3,000 than a vocational rehabilitation counselor at \$6,000. If the independent-living bill were enacted, home teaching salaries would undoubtedly come within the scope of the legislation. Both salaries and standards would improve, and a broader program of services would be made available to the blind. This would be a clear gain and much to be desired.

On the other hand, the independent-living bill as it now stands would further complicate and confuse vocational rehabilitation services for the blind. It would likely mean that fewer blind persons would be placed in competitive employment.

The "independent living" bill is a logical outgrowth of the 1954 amendments to the Vocational Rehabilitation Act. Before 1954 the emphasis in rehabilitation was on vocational training and job placement. The Federal regulations were so drawn that considerable incentive was given to the States to place disabled persons in competitive employment. The 1954 amendments as passed placed the emphasis on physical restoration and what has been called "medical rehabilitation." The Federal regulations were changed to reflect this new emphasis. The term "remunerative occupation" was defined to mean (subpt. A, 401.1p) "employment in the competitive labor market; practice of a profession; self-employment; homemaking, farm or family work (including work for which payment is in kind rather than in cash); sheltered employment; and home industries or other homebound work of a remunerative nature." A State could, and still can, claim a vocational rehabilitation closure on a person making 10 cents an hour, making no salary at all, drawing more public assistance than when the State rehabilitation agency took his case, making pot holders, or returning home to sit in an armchair (a "family worker") after having been operated

on for a cataract. Since "rehabilitations" of this type are counted as "closed, remuneratively employed," as are rehabilitations involving the more difficult task of placing disabled persons in competitive employment, the incentive is to make these easier "placements."

If the "independent living" bill should be enacted without substantial changes, it would continue the trend which was begun in 1954. Agencies for the blind would probably further deemphasize their job hunting and placement activities and would spend even more time testing, giving physical restoration services, counseling doing diagnostic work, and (most especially) helping the blind client to achieve "independent living"—but not a job.

The 1954 amendments to the Vocational Rehabilitation Act and the proposed "independent living" amendments point up the differences between vocational rehabilitation of the blind and vocational rehabilitation of other disabled persons. The blind, of course, comprise only a small fraction of the total number of disabled people in the Nation. Therefore, administrative planning and program emphasis at the Federal level and in those States having no special vocational rehabilitation agency for the blind are usually in terms of the total group, not in terms of the special needs of the blind.

The rehabilitation of the average disabled person usually involves medical work or some type of physical therapy—learning to use prosthetic devices, learning to walk or use muscles after polio, developing motor coordination, learning to live with one's limitations after a heart attack, correcting a speech defect, or learning to use a hearing aid or brace. In short, rehabilitation for the average disabled person who is not blind usually means physical restoration in one form or another, or some related process. When rehabilitation is viewed in this light, the 1954 amendments and the present "independent living" legislation are logical next steps. Increasing stress is placed upon diagnosis, medical services, therapy and physical restoration. Vocational rehabilitation services and hospital services are beginning to be regarded as related parts of one overall process. The disabled person is more and more thought of as a "patient."

Rehabilitation of the blind, on the other hand, is something else again. The average blind person in need of rehabilitation does not have a health problem. He is not sick. He does not need physical restoration. Lenses will not help him. He cannot be taught new techniques for using his eyes. His needs are entirely different from those of the "patient." He must have help in adjusting to his blindness. He must come to an understanding of the fact that it need not keep him from doing the things he has always done. He must have training in skills and techniques—independent travel, braille and typing, etc., above all, he must have help in finding a job. The average blind man, just as the average sighted man, is not a good salesman. He needs a vocational rehabilitation placement man to help him convince an employer that he can do a job. Considered in these terms, the 1954 amendments did not advance rehabilitation of the blind. Nor, as now drawn, would the "independent living" bill do so. Medical help and physical restoration are vitally important services. They are necessary for the blind as well as other groups. The question is not their importance, but by whom they should be administered, what emphasis they should receive, and that their relationship is to vocational rehabilitation.

In view of the foregoing comments the following specific proposals are made:

(1) Public Law 565 should be amended so as to provide for Federal matching funds as grants-in-aid to the States for home teaching programs for the blind, regardless of what department of State government administers such program. The Federal share of the cost of the home teaching program should be the same as the Federal share for the State under section 2 of Public Law 565.

(2) If the independent living bill (H.R. 3465) or any similar legislation is enacted, any agency of State government should be permitted to administer the independent living program. If the independent living program for the blind is administered by a State agency which also administers to program of vocational rehabilitation for the blind, the personnel (other than administrative) engaged in the day-to-day operation of one program should not be permitted to spend any time working in the other program.

(3) Public Law 565 should be amended to require changes in the reporting systems of the State agencies doing rehabilitation of the blind, and in the reporting system of the Federal Office of Vocational Rehabilitation a more realistic definition of "remunerative employment" should be established, and a clear differentiation should be made between types of rehabilitation closures.

(4) The services contemplated under the independent living legislation are greatly needed to promote the general welfare of the blind, but they should be

regarded more as health, welfare, and medical services than as rehabilitation, and they should be so planned and administered as not to weaken or water down the program of helping the blind to achieve regular, competitive employment. I thank you.

STATEMENT OF WENDELL P. BUTLER, SUPERINTENDENT OF PUBLIC INSTRUCTION,
KENTUCKY DEPARTMENT OF EDUCATION

While both rehabilitation and special education programs are for the handicapped, they are, by the nature of their programs, quite different in their aims, approaches, and services rendered. While rehabilitation services are designed to be rendered directly to the person seeking the service, special educational services are instructional in nature and the service of the State agency is directed more toward the local school system rather than a specific child or youth. These programs should be coordinated in an attempt to provide a continuous and logical program to the handicapped of all ages.

In view of the above distinction between rehabilitation and special education, we recommend that the implementation of Federal legislation and aid for special education programs be assigned to the Federal and State personnel responsible for these programs.

SCHOLARSHIP

We recommend that consideration be given to Federal legislation providing scholarships for teachers of all types of exceptional children. We further recommend that this legislation provide for the allocation of a proportionate number of these scholarships to each State and territory of the United States, in addition to grants-in-aid to institutions of higher learning.

In this manner, we believe Federal legislation and aid could assist materially in alleviating local shortages of qualified special education teaching personnel.

HOUSE JOINT RESOLUTION 494

Title I: We recommend that consideration be given to the expansion of title I of this resolution to include aid for the training of teachers of hard-of-hearing children.

Title II: We recommend that consideration be given to the expansion of title II to include training of speech correctionists and audiologists on the undergraduate level in order to meet the great need for speech and hearing personnel in public school systems.

STATEMENT BY MRS. J. A. RICHARDSON, AMERICAN SOCIETY OF BLIND PERSONS,
DALLAS, TEX.

As president of the American Society of Blind Persons, I have requested time to present the views of our organization concerning pending and needed legislation for the blind. We believe that the following program if adopted would be greatly beneficial to blind persons.

(1) One of the acute problems in the South and one which creates very real difficulty for many in Texas is created by the importing of brooms. Many of our blind people are engaged in the manufacture or sale of brooms. Because of cheap labor and inferior materials, the imported brooms are sold much cheaper than our blind manufacturers and salesmen can afford to market their products. Figures which we have obtained from a Mexican broom factory place the wholesale price of a household broom at \$3.72 per dozen. Our blind manufacturers must receive for its equivalent made in the United States \$9 per dozen. There is a corresponding difference in the prices of other types of brooms. Information which we have obtained from the U.S. Tariff Commission state that the number of imported brooms has greatly increased during the past few years. We request—

(a) That the duty on imported brooms be raised.

(b) That the quantity of imported brooms be limited.

(2) One of the most profitable businesses in which blind persons are engaged is the operation of vending stands, many of which are on Federal property. I am a stand operator's wife. I believe that our experience will, quite vividly, depict the plight of stand operators. Our business is located in the lobby of the Terminal Annex Post Office. There is, on another floor of that building, an

employees' cafeteria. We have never questioned their right to operate this cafeteria, or done anything to curtail its business. On the third floor of the building, there were two drink machines from which we received the proceeds. The Post Office Department alleged that these machines were hindering production and ordered their removal. They were not taken out of the building, but were placed in the cafeteria area. In 1957 the cafeteria was integrated. Immediately business fell off to such an extent that they had to close. The Post Office Department then asked the General Services Administration to order the removal of the soft drink box from the lobby stand. I protested to our Congressmen. During the next 7 months the General Services Administration and the Post Office Department furnished them with a great deal of incorrect and misleading information. It is true that in our case vending machines have been installed from which we receive half the proceeds so that our income has not been greatly reduced. Some operators have lost heavily. We request, therefore that the Congress provide for the setting up in each region a neutral arbitrations board, and that this board shall be authorized to—

- (a) Conduct fair hearings for stand operators.
- (b) Conduct such hearings in the city in which the operator resides.
- (c) Subpena such witnesses and such records as it needs in order to ascertain the facts in a given case.
- (d) Hear an appeal by the State agency for the blind when that agency has been denied the right to install a vending stand in a Federal building.
- (e) Make mandatory decisions except that appeal from the decision of the board may be made to a Federal court.
- (f) Interpret departmental regulations affecting vending stand and vending machines.

We request also that the definition of the vending stand be expanded to include snack bars.

We believe that in the distribution of aid to the blind, those who are unemployable, should be dealt with most liberally. We believe that in computing the resources of a recipient of aid to the blind, the first \$1,200 of income per year should be exempt. At present this applies only to earned income.

We will very much appreciate it if your committee will recommend to organizations of and for the blind that they attempt to settle among themselves any differences they may have concerning Federal legislation. In 1957 we organized the American Society of Blind Persons. Two of the purposes set forth in our bylaws were: To promote understanding and cooperation between the agencies engaged in work for the blind and the blind people of the United States, and to promote constructive legislation for the blind. With these purposes in view we have, on two occasions, asked for a conference of representatives of these organizations to attempt to reach agreement on proposals for legislation. Both attempts were unsuccessful.

We appreciate the opportunity to present our views on the needed legislation for the blind. Thank you.

Mr. ELLIOTT. The subcommittee has heard 34 witnesses today, and we are going to recess until 9:30 in the morning.

I want to express the appreciation of the subcommittee to everybody who has helped out in this process of our own education today. You have been very kind, helpful, and thoughtful. We appreciate it and look forward to seeing you again tomorrow morning.

(Whereupon, at 5:35 p.m., the subcommittee recessed, to reconvene at 9:30 a.m., Thursday, January 28, 1960.)

SPECIAL EDUCATION AND REHABILITATION

THURSDAY, JANUARY 28, 1960

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON SPECIAL EDUCATION OF THE
COMMITTEE ON EDUCATION AND LABOR,
Cullman, Ala.

The subcommittee met at 10 a.m., pursuant to recess, in the county courthouse, Hon. Carl Elliott (chairman of the subcommittee) presiding.

Present: Representatives Elliott, Green, Daniels, and Giaimo.

Also present: Representative Albert H. Quie.

Staff members present: Dr. Harry V. Barnard, research director; and Dr. Merle Frampton, director, study on special education and rehabilitation.

Mr. ELLIOTT. The Subcommittee on Special Education will come to order.

Today we have 32 witnesses scheduled. In order to accommodate everybody and in order that our friends may catch their planes this afternoon, it will be necessary that we push right along. We will have to limit our witnesses to 10 minutes, and I will have to be more careful that the 10-minute rule is observed today, I guess, in order to see that we do finish.

We are happy to have the interest that has been exhibited in these hearings. We are happy to have our visitors and friends attend and show their interest as well.

We are happy to have my old friend Kelley Herring today, along with Joe Corry of Oakman, Ala.; the high school class in civics from the local high school; and Mr. Blalock from the University of Alabama, with all of our other visitors and friends.

It appears that our weatherman has really played a trick on us today, in spite of our announcements about our fine weather in the Southland. But I hope by midday this may improve. I am afraid we will never be able to get our friends to believe that we have the fine weather for which we are famed if it does not improve soon. Yesterday was bad enough, I thought, but today is downright embarrassing.

Our first witness today is George G. McFaden, supervisor, Services for the Blind, Vocational Rehabilitation Division, Alabama State Department of Education, Montgomery, Ala.

STATEMENT OF GEORGE G. McFADEN, SUPERVISOR, SERVICES FOR THE BLIND, VOCATIONAL REHABILITATION, DIVISION, ALABAMA STATE DEPARTMENT OF EDUCATION, MONTGOMERY, ALA.

Mr. McFADEN. Mr. Chairman, and members of the Subcommittee on Special Education, I am George G. McFaden, supervisor of Serv-

ices for the Blind, in the Alabama Division of Vocational Rehabilitation.

I wish, if I may, to testify in favor of the provisions of H.R. 3465 introduced during the 86th Congress by the Honorable Representative Carl Elliott of Alabama. The addition of the three titles to our present Rehabilitation Act, as provided for by H.R. 3465, would greatly extend and strengthen rehabilitation services for the severely disabled citizens of our State.

My remarks shall be limited primarily to the establishment of workshops and other rehabilitation facilities.

Since the enactment of Public Law 565 in 1954, one of my responsibilities has been to help develop and plan workshops and other rehabilitation facilities. The Alabama Division of Vocational Rehabilitation has worked jointly with the Alabama Institute for the Deaf and Blind, county and city boards of education, State-supported trade schools and other organizations and institutions in the establishment of some 14 workshops and rehabilitation facilities. We have worked closely with the Alabama Society for Crippled Children and Adults, Inc., in the operation of some of these workshops and facilities.

There are certain limitations imposed under the provisions of the present Rehabilitation Act, Public Law 565, which cause unjust hardships and conditions which would be overcome by the passage of H.R. 3465. I would like, if I may, to give some specific examples.

Under the present act, Federal financial participation is available only for the expansion, remodeling, or alteration of existing buildings to adapt such building to workshop or rehabilitation facility purposes or to increase their effectiveness for such purposes. No Federal financial participation is available to construct a new building or to participate in expanding, remodeling, or altering a new building if it were intended in the original plans for the construction of the building that it would be used for a workshop or a rehabilitation facility. This limitation has caused a tremendous hardship financially and otherwise in establishing a comprehensive center and workshop for the blind at Talladega, Ala.

The officials of the Alabama Institute for the Deaf and Blind were willing to join with the division of vocational rehabilitation in establishing and operating a comprehensive rehabilitation center and workshop. The need for such a center and workshop had been established. Everyone was in agreement that it should be located at Talladega as this was the present location of the State-supported school for both deaf and blind.

The Alabama Institute for the Deaf and Blind did not have an existing building that would be suitable to expand, remodel or alter to be used for this purpose. In fact, there was a dire need for the institute to carry out an extensive building program to meet the demand for the regular school program.

We did the best we could under the circumstances. The institute obtained title to three old buildings located at Brecon on the outskirts of Talladega. These were poorly constructed warehouses that were used for temporary storage of ammunition and supplies during World War II. These buildings were not suitable, by any stretch of the imagination, to be converted into an evaluation, adjustment, training, and workshop center for the blind. However, having no other alter-

native, the institute and the rehabilitation agency in a piece-meal fashion, in order to comply with existing regulations, have over a period of 4 years, developed one of the most comprehensive rehabilitation centers and workshops for the blind in the country.

It would have been much more feasible and economical to have constructed a new facility that would have been more permanent and certainly better adapted to the purpose.

Another example illustrating how undue hardships were imposed by existing restrictions is the Mobile Association for the Blind. Here again we were forced to expand and remodel an existing building which was not suitable for this purpose instead of constructing a suitable building to house a workshop for the blind.

The Mobile Association for the Blind has an old building which could be sold. The proceeds from the sale of this property could be used to match Federal funds in the construction of a much more adequate and suitable building for the facility if it were not for the two restrictions in the present law, namely, the use of the funds of a non-profit agency to match Federal funds and the construction of a new building. The passage of H.R. 3465 would remove these restrictions.

I do not believe it is the wish of the Congress to continue to impose such restrictions to the development of rehabilitation facilities and workshops of this nature.

The needs for the deaf are similar to those for the blind. Specialized facilities for diagnostic evaluation and training of the deaf are necessary for successful rehabilitation. The Alabama Institute for the Deaf and Blind and the division of vocational rehabilitation are completing plans to establish a comprehensive center for the deaf similar to the one now in operation for the blind. We will encounter some of the same restrictions unless the present regulations are amended.

The establishing and operating of a specialized comprehensive rehabilitation facility is expensive. We have learned through experience that a period of several years is required before a comprehensive facility of this nature can be properly staffed and put into full operation. We feel that continued Federal participation beyond a 1-year period for staffing such a facility will greatly expedite the development of more comprehensive facilities. This, with Federal participation, in the training of key personnel, will help to overcome some of the difficulties now encountered in establishing and operating workshops and rehabilitation facilities.

Thank you, sir.

Mr. ELLIOTT. Thank you very much, Mr. McFaden.

Are there questions of Mr. McFaden?

If not, we thank you, Mr. McFaden, for your fine testimony.

Mr. ELLIOTT. Our next witness is Mr. John Wallace, President of the Florida State School for the Deaf and Blind at St. Augustine, Fla.

STATEMENT OF JOHN WALLACE, PRESIDENT, FLORIDA STATE SCHOOL FOR THE DEAF AND BLIND, ST. AUGUSTINE, FLA.

Mr. WALLACE. Mr. Elliott, Mrs. Green, and other members of the committee, I, too, am very happy to be here to appear before you a few minutes. However, I doubt if I could add too much to what other

members of our workshop have added. But there were a few points that I wished to emphasize.

The Florida school is the second largest residential school in the country, having departments for both deaf and blind children, Negro and white. We have 634 students with a teaching staff of 80. In this staff, 30 of them are in our departments for the blind, and of these 30 instructors only 1 had previous training to teach blind children before coming to us. This one Negro instructor was trained by Dr. Frampton in New York.

Therefore, I want to emphasize the importance for establishing more training centers or teachers and personnel for visually handicapped children.

As far as I know, there are only five recognized training centers at this time: Syracuse, Peabody, Hunter College, Perkins, and San Francisco State.

There certainly is a great need for Federal grants-in-aid or scholarships to influence worthwhile people to come into this very important work. That, of course, is true for both visually handicapped children and hearing-handicapped children.

One of the most alarming things that we see is the children who come in with multiple handicaps. So many of our visually handicapped children have a second or even a third major handicap. Some of these children are emotionally disturbed. Some of them are pre-psychotic. There are no regional diagnostic residential centers where these children can be sent for observation and treatment.

To me, that is one of the most urgent needs. In these diagnostic centers they could train various staff members to help these children. Also, we need more careful screening so that children may be more properly placed.

Most of the recommendations will be included in Mr. Woolly's report. We were in that workshop for 2 days in Atlanta. So I will not cover the points that will be made there.

Another important thing is the expanding need for educational equipment. Every legally blind child is allowed approximately \$30 for equipment, and there is a ceiling on that at the American Printing House. This is to be raised if each child is to be supplied with this very important and expensive educational equipment and educational aids. For instance, in Florida 400 children are registered at the American Printing House for the Blind: 175 in the residential school, and over 200 in the public schools. However, they cannot get the equipment needed, and we are unable to supply them with this.

I would like to point out the expense of just a few items. For instance, a braille writer, a Perkins writer is in the neighborhood of \$92. Braille maps and globes are around \$300. We have world history books where the volumes cost \$70 per set. We happen to have six sets of those.

So that will give you some idea of just a few of the materials that are needed.

A study that was made in New York State of blind children, as of October 1956, had 2,773 children under 21 years of age, and since New York has nearly one-tenth of the population of the United States, it can be estimated that there are somewhere between 30,000 and 35,000 visually handicapped children under 21 years of age in the country. Of course, many of these may not be educable.

I would like to point out the main things are scholarships to train personnel, the establishment of regional diagnostic centers, and expanding educational equipment.

Mr. ELLIOTT. I recognize Mrs. Green.

Mrs. GREEN. What is the definition of a legally blind person?

Mr. WALLACE. It is usually considered 20 over 200.

Mrs. GREEN. Is that the legal definition?

Mr. WALLACE. That is the legal definition of blindness. Of course, there are many children in our schools who have more sight than that but need our special help.

Mrs. GREEN. How is this definition established?

Mr. WALLACE. I presume medical men have established that.

Mrs. GREEN. Is that uniform throughout the United States?

Mr. WALLACE. Yes.

Mrs. GREEN. I was thinking it was much less than that.

Mr. DANIELS. Mr. Wallace, you said there were five schools for the training of visually handicapped people. Do you know how many teachers were in training in those schools in 1959?

Mr. WALLACE. No, I do not.

Mr. DANIELS. You do not have any figures?

Mr. WALLACE. But I know that I have been head of a residential school for 15 years, and I have never had but one application from a person who had had training with the blind prior to that.

We have employed people who have had experience in other schools. Most of us give inservice training. It is necessary, and we hold workshops.

So most of our personnel have received on-the-job training.

Mr. DANIELS. Thank you.

Mr. WALLACE. One girl we sent to a training center, to Peabody, after she received her Master's degree, and then she went west.

Mr. ELLIOTT. That is all too often the case, is it not?

Mr. WALLACE. Yes.

Mr. ELLIOTT. The gentleman from Minnesota, Mr. Quie.

Mr. QUIE. You said we needed more training centers. Do you think there is a possibility that facilities are sufficient in those five to greatly expand the number of teachers they turn out each year, if some assistance, similar to what is proposed for the deaf and speech-corrective teachers, were given for the blind?

Mr. WALLACE. No. I think many more centers are needed, because teachers in training must have places where they can do their practice teaching.

Many of these schools, while maybe they do not have as many trainees as they could take, they would not have the facilities to take care of large groups.

Mr. QUIE. How many would be needed each year to take care of your needs?

I imagine that, no matter what happens, a substantial number of your teachers would be trained in your schools.

Mr. WALLACE. Yes. I have no idea how many would be needed, but I know that in our day classes in Florida, I receive letters wanting me to recommend a teacher for their special classes. In most cases, they just employ a teacher.

Mr. QUIE. Do the public schools of Florida have some classes for the blind?

Mr. WALLACE. Yes. Small day classes. Some of them are placed in classes with normally situated children. However, many of these small day classes, they will often have hard-of-hearing children, blind children, one with cerebral palsy, and many of the special classes have a number of different types of handicaps in one schoolroom, which is very undesirable.

Mr. QUITE. It is practically impossible for a person to be well trained in handling all of the handicaps; is that right?

Mr. WALLACE. That is true.

Mr. QUITE. As you went along you said that many of these 30,000-35,000 blind probably would not be educable. Is the incidence of mental retardation in the blind much greater than, we will say, in sighted people?

Mr. WALLACE. I have no figures to bear that out. I would not know except that I do know that we are beginning to see more and more visually handicapped children with additional handicaps; for instance, brain damage, cerebral palsy, epilepsy.

Mr. QUITE. Is that because so many of the children are received at childbirth?

Mr. WALLACE. That is right, possibly. Many of the premature babies are received.

Mr. ELLIOTT. Thank you very much, Mr. Wallace.

Mr. WALLACE. Thank you.

Mr. ELLIOTT. Our next witness is Dr. W. W. Wilkerson, Jr., medical director of the Bill Wilkerson Hearing and Speech Center of Nashville, Tenn.

We are happy to have you, Dr. Wilkerson, and I doubt if there is a member of this committee who is not familiar with your deep and untiring devotion to this cause. We look forward to what you have to say. We regret that we must impose the time limit.

**STATEMENT OF DR. W. W. WILKERSON, JR., MEDICAL DIRECTOR
AND CHAIRMAN, THE BILL WILKERSON HEARING AND SPEECH
CENTER, NASHVILLE, TENN.**

Mr. WILKERSON. Hon. Carl Elliott, and distinguished members of the House Subcommittee on Special Education, I am grateful for the opportunity to present testimony on behalf of House Joint Resolution 494, introduced by Mr. Elliott, and companion resolutions.

I wish to congratulate you on your previous achievements.

Though wholeheartedly supporting part I of this bill, I shall only discuss the need for part II, as I am more informed in that area.

In order to avoid repetition of previous testimony, I shall discuss the national needs rather than the problems of this region.

Of Tennessee, I would say that we are very proud of our hearing and speech program, of the fine centers, superbly equipped.

We need trained personnel in Tennessee as badly as any other State in the Union. As a matter of fact, we are delaying at our own center a doctoral program because of the lack of qualified personnel.

With the leadership of Representative Fogarty in 1955, for the first time, to my knowledge, Congress specifically supported a hearing and speech program. Yet, comparatively little has been done for the

largest segment of our disabled population, those persons with hearing and speech defects.

The Public Health Service of the U.S. Department of Health, Education, and Welfare, published two surveys; one, compartments by types, sex and age, July 1957 to June 1958; and, two, health statistics, children and youths, selected characteristics, for the same date.

The first of these surveys deals with the handicapping disability of all ages, and shows the following pertinent facts:

Hearing and speech defects were most frequently listed as untended with only 6-8.1 and 59.3 percent, respectively, being seen by a physician.

There were 23,815 impairments found in this survey. Incidentally, it was a survey of 36,000 homes, involving 115,000 people. Of this number—23,000—there were 5,714 with hearing impairments, 1,098 with speech defects, total deafness in 109; visual impairments, including blindness, 3,024; mental retardation, 240; cerebral palsy, 112.

Broken down into percentages, hearing and speech impairments accounted for 29 percent in all ages. In the next largest group—visual impairments—the percentage was only 8.7 percent.

In other words, hearing and speech impairments, percentagewise, were almost four times as large as in any other single impairment.

Based upon the population of the United States, this health survey states that there were 24 million impairments and that 7 million of these were hearing and speech impairments.

While these figures are most conservative, the survey reveals more than one-third of all impairments are due to hearing and speech defects.

In the publication dealing with children and youth, from age 0 to 14, the percentage of visual impairment is 8 percent; orthopedic, 36 percent; hearing and speech defects, 41 percent. For ages 15 to 24 the percentage of visual impairment is 7 percent, hearing and speech impairments 23 percent, orthopedic 59 percent. These figures represent the distribution of impairments in handicapped groups.

It is generally estimated that 50 percent of those persons handicapped with hearing and speech defects have major disabilities. This means that over 20 percent of the age group of 0 to 14, and 11 percent in the age group of 15 to 24 have major disabilities compared to three-tenths of 1 percent in the largest group, orthopedics.

The number of colleges and universities training audiologists and speech pathologists from 1953 to 1954 was 115. I do not have more recent information, but I think the facts would be virtually the same. Only 12 of these institutions granted one or more Ph. D. degrees, and only 53 granted one or more masters degrees.

According to material prepared by the Department of Education as of July 1, 1957, based on membership in the American Speech and Hearing Association, there was only an average of 128 persons graduated in hearing and speech with a master's degree, and 31 with a doctoral degree since 1949.

The passage of this resolution is needed because, one, a program for work of this magnitude should have direct authorization by the Congress; two, it will give stature to a great humanitarian need; three, it will develop professional workers interested in all hearing

and speech problems for all people regardless of age, vocation, non-vocation, education, or finances.

A major program, rather than a subdivision of some agency undefined by Congress, should be developed.

The Office of Education has for many years had the Federal responsibility of the teachers of the deaf program, and has done an excellent job. Its experience in this field will augment part I of this resolution. The Office of Vocational Rehabilitation has a hearing and speech program with great merit.

Therefore, to utilize the great experience and the fine personnel versed in this graduate training program, part II of this resolution is properly placed in the Office of Vocational Rehabilitation.

A broad base is needed for the development of a program as anticipated under part II, as the field of communication covers many facets, such as geriatrics, psychiatrists, surgery, pediatrics, medicine as a whole, audiologists, speech pathologists, psychology, rehabilitation, physics, social service, and so forth.

It is easy for one such as I to urge that this resolution be placed on the agenda of the House of Representatives at this session, as I carry neither the responsibility nor the knowledge requisite for enactment of legislation. Yet, I would urge action for the following reasons:

One, based on statistics, it seems that this resolution should receive top priority in the field of care for the handicapped.

Two, there is an urgent need each year, with an increase of population, the problem becoming more acute: deafness of individuals in the armed services, industry, and the veterans' group constantly rising.

You will be interested in knowing that I was just recently told that the aerospace development program had to discard 130,000 hearing tests because of the fact that the personnel that made the tests were not qualified.

Three, many Congressmen have manifested their interest in the passage of this resolution.

Four, if this resolution is not passed at this session, the entire legislative procedure must necessarily be begun anew at the next session, with some change in membership in each House.

Five, the passage of this bill will establish a pattern for other needed legislation in the general field, and will in no way interfere with subsequent legislation as needed in the hearing and speech field.

It was realized by the hearing and speech division of the workshop, just held in Atlanta, that the passage of House Joint Resolution 494 would not answer all the needs.

This will not appear in your report, and that is the reason I am giving it to you. However, it was unanimously approved, so far as I could tell, as it was thought that the passage of this said resolution would answer our greatest needs.

As you know, many individuals and organizations unselfishly interested in this problem are urging the passage of this resolution. The fruits of its passage will strengthen our Nation socially and financially, and bring hope to many currently unhappy homes.

Mr. Chairman, if this was an organizational meeting with you as chairman, and your subcommittee as officers of said organization, I would move, sir, that we give you a rising vote of thanks for your

devoted labor of 2 days. As it is, I will just say thank you. I appreciate your coming to the South.

Mr. ELLIOTT. Thank you.

We have enjoyed your testimony, Dr. Wilkerson, and enjoyed seeing someone with devotion and the inspiration that you have for this cause.

(Dr. Wilkerson's full statement follows:)

STATEMENT BY DR. W. W. WILKERSON, JR., MEDICAL DIRECTOR AND CHAIRMAN, THE BILL WILKERSON HEARING AND SPEECH CENTER, NASHVILLE, TENN.

Mr. Chairman, members of the Subcommittee on Special Education, and guests, I am privileged to have the honor of testifying before this distinguished body in favor of these resolutions.

GENERAL DISCUSSION

Individuals who are handicapped with hearing and speech difficulties do not present a dramatic picture. One's sympathy is not automatically aroused as, for instance, it is in cases of lameness, blindness, or cerebral palsy. Hence, the hearing and speech victims frequently are objects of ridicule; often are considered stupid, even if they have normal or high IQ's; may be unjustifiably placed in homes for feeble-minded; or may suffer from difficult family relationships. Can't each of us recall the teasing which a stutterer or cleft palate child received at school?

Fifteen percent of adults over 65 years of age have hearing and speech defects. More children are handicapped with hearing and speech disorders than from any other single cause. Yet neither foundations, nor wealthy individuals, nor governmental agencies have given more than token aid to those persons. Since a larger percentage of cases with hearing and speech disabilities can be restored to a productive life than in any other handicapped group, isn't it reprehensible that so little is being done?

Communication between individuals is a basic human need; only humans can talk. Communication is necessary for a normal religious, emotional, social, and economic life. Without hearing, one would never listen to music, or hear his mother's voice. Without ability to talk, one is a social outcast, shunned, merely watching life from the sidelines. If not also blind, he sees, but without understanding. He is unemployable in the true sense of the word.

CONDITIONS AND DISEASES COMPLICATED WITH COMMUNICATION PROBLEMS

What are some of the causative factors for loss of normal communication? Poliomyelitis of the paralytic type, cerebral palsy, and brain injury may cause partial or complete paralysis of the nerves controlling the voice, and also may involve the sense of hearing. While these complications are not uncommon, no actual statistics as to the percentage of cases so affected are available.

Hereditary defects frequently produce all types of hearing and speech problems of varying intensity. Such cases frequently are considered deaf, although a small amount of hearing is usually present. They naturally have no speech, as one cannot learn to speak without having heard speech. In Nashville we have, at this time, 52 cases of this type in the special acoustic classrooms of our county school system. These severely damaged cases will learn to speak and receive at least some education. We are fortunate in having excellent hearing and speech personnel for these classes. It is remarkable that one-third of these children, who had neither hearing nor speech before coming to the hearing and speech center, will enter a regular grammar school and receive a normal education.

Some speech impediments are due to environment. Parents, through over-earnerness, or impatience, may induce children of certain types to stutter.

Mental health and social adjustment problems are the rule in persons handicapped with hearing and speech defects. Dr. Arthur J. Lesser of the U.S. Children's Bureau has stated: "It is obvious that impairment of hearing in a child sets up a chain of disturbances in his development which affects seriously his mental, emotional, and social development." It is, therefore, understand-

able that a large category of the patients in mental hospitals and clinics are there primarily because of communication problems. To put it another way, the mental health problem will decrease in magnitude with favorable action by the Congress on this resolution.

The Department of Medical Genetics, New York State Psychiatric Institute, Columbia University of New York City, under the sponsorship of the Office of Vocational Rehabilitation has recently collected information "on over 10,000 cases of deaf residents of New York State, including many who had never been to school and were living on isolated farms or more or less anonymously in rural homes and institutions." Since this survey was necessarily incomplete, I am sure that the number of persons so situated is far in excess of 10,000. This is tragedy of the highest order.

Recently it has been estimated that 2,500 patients have their voice box removed each year because of cancer. Yet, without proper voice training, i.e., speech sounds made in an abnormal manner, none of these persons can return to a normal activity. Without training, they remain mute.

Apoplexy, a "stroke," is a hemorrhage into the brain. Unless the hemorrhage is quite small, it usually produces a paralysis of some part of the body. Frequently speech is affected. It also may produce aphasia, i.e., failure to call objects by their correct name, or failure to associate a word or name properly.

Viral diseases may produce loss of hearing. Scarlet fever, and measles, particularly in the early months of pregnancy, may cause many disabilities including deafness of the newborn.

Cleft palate occurs in about 1 out of 700 births. This causes both speech impairment and loss of hearing. A team of highly trained professional personnel, including physicians, speech pathologists, orthodontists, etc., is required for the attainment of a successful result.

Industrial and occupational deafness, due to the exposure to loud noises day after day, produces a loss of hearing in many persons. An old medical term, "boilermaker's deafness" is most expressive. However, it is now recognized that such deafness occurs in all heavy industries, workers around jet planes, and in aviators flying both in the military and civilian planes. Until recently, no provisions under workmen's compensation laws recognized this disability. Fortunately, and correctly so, a few States now provide for compensation for such loss of hearing. Much more legislation is needed in this field.

NEED FOR COMPREHENSIVE FEDERAL GRADUATE TRAINING PROGRAM, CONCENTRATED IN ITS ENTIRETY TO HEARING AND SPEECH

No figures or percentages estimating the number of people affected with hearing and speech disorders are entirely accurate. Due to the lack of trained personnel, the majority of our children, workers, and adults in general have not even been tested.

I have stated on numerous occasions that 10 to 15 percent, or 20 million of our population were handicapped with hearing and speech defects. However, recently Dr. Aram Glorig, director of research, Subcommittee on Noise of the Committee on Conservation of Hearing of the American Academy of Ophthalmology and Otolaryngology, stated that, based on sound statistics, approximately 20 million males between ages of 10 and 59 are estimated to have a definite loss of hearing, and of these, one-fifth, or 4 million have a severe hearing loss. Adding these figures to the number of females handicapped with hearing and speech defects, one obtains an astronomical figure. However, more males are involved than females. It is estimated that 1,700,000 males between the ages of 50 and 59 are entitled to workmen's compensation due to hearing loss.

At least 10,000 children are forced to quit school each year because of hearing or speech disability, or 100,000 every decade. Do these children not deserve the same consideration as the dull or noncooperative students?

It is estimated that there are only 4,000 workers in the hearing and speech field, and that at least 50 percent are poorly trained. Further, it is estimated that a minimum of 25,000 additional professional qualified workers are needed now.

According to material prepared by the Department of Education as of July 1, 1957, there was only an annual average of 128 persons graduating in hearing and speech with a master's degree, and 31 with a doctoral degree since 1949. The services of some of these persons are lost because of marriage and for other

reasons. This same publication states, "The most serious obstacles to provision of needed services for this large group of handicapped children are an acute shortage of trained personnel and lack of sufficient knowledge, etc." It also stated that only one child in five received needed care, and further that "It would seem that State departments of education, local school units, and colleges and universities, face an all but insurmountable task in meeting this enormous problem."

COMPARISON OF FREQUENCY OF HEARING AND SPEECH DEFECTS WITH OTHER HANDICAPPING DISABILITIES

Dr. A. R. Shands, Medical Director of the Alfred I. Dupont Institute states that less than 1 percent of the children are handicapped with cerebral palsy; 3.2 percent of the children are handicapped with mental retardation. The American Foundation for the Blind states that one-third of 1 percent of school-age children are handicapped with blindness.

Think how much has been done by national foundations, individuals, and governmental agencies for the above handicapped groups, and how little has even been attempted to aid the much larger group of children just as severely handicapped with hearing and speech defects. Dr. Shands further stated that he would prefer any handicap in preference to loss of communication.

COST IN DOLLARS TO THIS NATION

Since there is no way to evaluate the suffering and heartaches in any disability, I shall only discuss the cost in money. The Veterans' Administration is paying annually \$42 million in compensation for service-connected hearing loss, and additional sums for hearing aids and their upkeep. I do not know the cost of the hearing losses of the non-connected-service cases. Much of this money could be saved if methods of prevention were developed.

The potential cost to industry is enormous. It is conservatively estimated that 1,700,000 persons in the age group of 50 to 59 years have work-connected hearing losses. Under the workman's compensation laws of Wisconsin and Missouri, if the claims averaged \$1,000, the total cost in this age group alone would be \$1¾ billion. This figure gives no consideration to other age groups. Most of this money could be saved by prevention.

No one knows the cost of operating the hearing and speech centers of this country. However, we can state that the centers in Tennessee spend a minimum of \$600,000 annually, excluding any funds for depreciation or real maintenance. Over \$2 million is invested in buildings and equipment. Every center in my State is understaffed, as professional personnel simply is not available.

Based on the survey made in New York, mentioned previously, and applying these figures to the total population of the country, it is estimated that over 103,000 deaf persons are in institutions, or hidden away in homes. At a cost of \$600 for mere maintenance per year per person, the total cost to the Nation is almost \$62 million. Some of this could be saved. Costs of other groups and intangible expenses cannot be estimated.

The greatest expense to this Nation is the loss of income of many of these persons, a great horde with no income. If these people were paying their potential taxes, perhaps income taxes could be reduced. To say the least, it would be an enormous sum.

ENACTMENT OF RESOLUTION

Results: Many additional speech pathologists, audiologists, teachers of the deaf, and other paramedical specialists will be added to the present short supply; existing teaching institutions will be stimulated and augmented by new ones; standards in these fields will be elevated; programs for recruiting students into these professions will be augmented; research workers will learn new methods for control of noise in heavy industry, better methods of testing hearing, means for prevention of hearing and speech disabilities, and more effective courses for habilitating and rehabilitating those individuals already affected. Teachers will be trained for teaching other students on the graduate and undergraduate level. With an increased corps, additional centers for rehabilitation, teaching, and research will develop throughout the Nation. Shortage of personnel definitely retards the development of these needed centers at the present time.

With an advisory committee of outstanding men and women representing many facets of the hearing and speech field, a comprehensive and coordinated

program will be developed. It will obviously require time to plan the basis for such a program.

A working conference on health aspects of hearing conservation, initiated by the departments of public health and vocational rehabilitation in May 1959, was attended by a large number of persons representing many professions involved in hearing and speech work. Both civilians and representatives of government were present. The following resolution was passed unanimously: "This conference recommends increased financial support of existing programs and creation of additional programs of support for the training of all shortage category personnel concerned with medical, audiological, educational, and research problems of hearing impairment."

There are precedents for legislation, such as is proposed in this resolution, to be found in certain training programs of the Department of Health, Education, and Welfare, and the National Defense Education Act of 1958. These governmental agencies are interested in the hearing and speech problem and are doing excellent work, despite the fact that their authorizations lie in a larger field, with graduate training in hearing and speech as only a small subdivision of their total interest. The number of persons handicapped with hearing and speech defects makes it imperative that units or subunits of government be given full responsibility for this important program. Also, there is no Federal law enabling a program to develop as specified in this proposed legislation.

Teaching institutions have been, and are, utilizing every known method to raise additional funds for teaching hearing and speech personnel, yet, year after year, because of lack of funds, relatively few persons are trained.

Some may say that local and State agencies should support all teaching programs in this field. State and local governments simply cannot cope with the problem, particularly in view of the fact that a great percentage of graduates in hearing and speech do not remain in their local areas. Graduates from my center, which has been teaching students for only 7 years, are now located in approximately 22 States. Truly, then, this is a Federal responsibility. Teaching institutions are pleading for the opportunity to serve. The handicapped persons are praying for help. For these handicapped people, I beg for your approval of this resolution. Humanity truly needs your help.

Mr. ELLIOTT. Our next witness is Miss Roberta Morgan, Jefferson County Coordinating Council of Social Forces, Birmingham, Ala. Is Miss Morgan here?

If Miss Morgan is not here, may I say that our next witness is Mr. J. J. Benford, past president of the Alabama Rehabilitation Association, Albertville, Ala.

STATEMENT OF J. J. BENFORD, PAST PRESIDENT, ALABAMA REHABILITATION ASSOCIATION, ALBERTVILLE, ALA.

Mr. ELLIOTT. Mr. Benford, we are happy to have you. We recognize also the fact that you are a member of the Alabama State Board of Education.

I regret that we must limit you to 10 minutes of testimony. But, with that understanding, you may proceed.

Mr. BENFORD. It is a pleasure to be here, Mr. Chairman, and members of the committee.

I come here as a private citizen, not as an expert in any of these fields. My remarks will be rather limited, but I would like to point out two or three facts, and, in two departments that your committee has under consideration, the special education problems of the mentally retarded, and I will follow that with a few remarks regarding rehabilitation needs in our State.

Thirty out of every thousand persons in the United States are classed as mentally retarded. This, therefore, represents a considerable segment of our population.

Who is a mentally retarded child?

He is a child with an impaired intellectual development, incapable of being educated properly and effectively through ordinary classroom facilities with normal children.

Out of this 30 mentally retarded children, 25 of them are classed as educable, and 4 out of that 30 are classed as trainable; that is, who might be taught to look after themselves and their own personal needs at home. And 1 out of the 30 is classed as totally helpless, and will probably need custodial care throughout his life.

The group that I am interested in is the 25 who are educable. They may profit from special educational facilities to make them economically useful and socially adjusted. His mental development is approximately one-half to three-fourths that of the average child.

The educable retarded can usually learn enough reading, arithmetic, and things like that to meet his daily needs. He will require special help for vocational placement, but may become self-supporting and capable of handling his own affairs throughout his life with some counseling.

The greatest problem of dealing with children in this class, then, is a lack of trained teachers to handle these groups.

If some incentive could be offered to interested teachers to take training in this field and other fields of exceptional education, we would have gone a long way toward a solution to the problem of exceptional education, particularly regarding these mentally retarded boys and girls.

Now I would like to go directly into the field of rehabilitation.

I believe the main emphasis in our State over the years has been placed upon vocational rehabilitation, and during the years I have had some rather close association with the program.

Figures which I am about to give you—and I assure you there will not be many of them—are taken from the records of the State rehabilitation service, and I have taken the liberty to round them out instead of giving the exact figures.

Since 1956 in Alabama the clients of the rehabilitation service—cases which have been closed as employed—in 1956 numbered about 1,950; 1957, 2,070; 1958, 2,240; and last year, 2,360.

This does not represent all the people in Alabama who had physical impairments and needed vocational rehabilitation. The current backlog is around 10,500 people who need this service.

The limitations of training are the staff, money, and facilities for handling. During the past 12 years this backlog of people needing vocational rehabilitation has increased in spite of additional staff and more facilities and increased budget. This backlog is due largely to the fact that we have about 5,000 people in Alabama suffering some disabling accidents or becoming disabled for some reason each year.

In 1956 we had 2,600 in round figures accepted for vocational rehabilitation; that is, actively on the list. In 1959 we had 3,080.

Alabama today has 14 facilities designed to help serve the more severely disabled who could not be served in the regular facilities available, such as hospitals, trade schools, and institutions of higher learning. The average daily capacity of these facilities, excluding the one in Mobile, is approximately 200. So you can see that 200 does not nearly meet the needs for rehabilitation in our State.

The number closed from the department of welfare rolls in 1959 was 430.

I might say that the average payment by the welfare department—the department of pensions and security, it is called in our State—the average payment per year in 1958 was \$456. The average cost of rehabilitation of clients is only \$435. That is a one-time expenditure whereas the welfare payments continue on and on year after year as long as they are on the rolls.

So, just from the standpoint of pure economy, it would pay us to look after rehabilitation of these people who need it.

I would like to give you a bit of personal experience in the field of vocational rehabilitation. For 23 years I owned and operated a printing business and a weekly newspaper. My first employee was a rehabilitation client who had started his training on the job in a shop down the street. He continued the training after coming with me.

I was so impressed with his work that I contacted the State rehabilitation service, and some of those gentlemen are here in the house today whom I contacted, and requested other trainees. They supplied my needs throughout the 23 years.

All these fellows were handicapped physically, and were eager to learn in order to become self-supporting citizens.

Only two shop employees during the 23 years that I operated this business were not physically handicapped. All the others were handicapped and trained on the job in the shop. Some of these men might well have been beggars on the streets, or clients of public welfare, or wards of some charity. Each has become a respected citizen and a self-supporting taxpayer in the community. Each of them has paid back in taxes many times over the cost of his rehabilitation.

As I see it, the great need now is for more facilities, for training, and for additional personnel to service the program of rehabilitation. I thank you for the privilege of appearing.

Mr. ELLIOTT. Thank you, Mr. Benford.

Our next witness is Mr. R. B. Bagley, supervisor, Crippled Children's Service, State Department of Education, Montgomery, Ala.

STATEMENT OF R. B. BAGLEY, SUPERVISOR, CRIPPLED CHILDREN'S SERVICE, STATE DEPARTMENT OF EDUCATION, MONTGOMERY, ALA.

Mr. BAGLEY. Mr. Chairman and members of the committee, I am R. B. Bagley, supervisor, State Crippled Children's Service, State Department of Education, Montgomery, Ala.

The State crippled children's service is a section of the division of rehabilitation and crippled children's service.

This service is closely coordinated with the vocational rehabilitation service and the program of education for exceptional children. The crippled children's service accepts responsibility of bringing about maximum physical improvement in crippled children in order that they can take full advantage of educational opportunities as well as social and emotional growth. All of these factors are directed toward the ultimate vocational rehabilitation of these children.

I would like to bring to your attention some of the problems confronting this service in the State of Alabama. I am sure these same

problems would be applicable to the crippled children's services in the other Southeastern States.

The first problem is the need for more Federal funds in serving these children.

The Congress has authorized a \$20 million appropriation to the Children's Bureau for the crippled children's program. The President has recommended to the Congress in the budget of the United States Government for the fiscal year ending June 30, 1961, \$16,667,000 for services to crippled children. It is our belief that the full \$20 million authorized by the Congress should be budgeted. Our belief is based on the following facts:

(1) The per diem cost of hospitalization has more than doubled in the last 8 years in this area. At the present, the crippled children's service is paying less than half of the audited reimbursable cost at cooperating hospitals. These hospitals cannot continue on this basis indefinitely.

(2) Prosthetic devices, which are artificial limbs, braces, corrective shoes, have more than doubled in price also.

(3) Adequately trained personnel is at a premium and only comparable salaries paid in business and industry will attract and hold these people in positions rendering services to the handicapped.

(4) The cost of travel for professional personnel, both in lodging and operation and maintenance of automobiles, has increased markedly.

All of these needs mentioned are necessary to maintain the program already in existence. It does not include any need for expansion of personnel or additional services to crippled children. I am sure that each of you will recognize that the more nearly normal a crippled child can be made in its childhood, the less burden he will be in later life on other public agencies, namely, vocational rehabilitation, public assistance, and public health.

At the present time there are over 400 children on the waiting list for hospitalization in this State for whom surgery has been recommended by the doctors on the staff of the crippled children's service. These are not children who have been selected for elective surgery, but these are children for whom the doctors feel that only surgery will correct or alleviate the existing crippling conditions.

We all recognize further that it is almost impossible for the badly handicapped child to attend regular classes in school. We also recognize that an enlightened and educated citizen is a better citizen.

The State of Alabama recognizes the need of education for these severely crippled children, and a special education program has been established. The crippled children's service, cooperating with the school authorities, has attempted to screen all of the crippled children for the public schools and to furnish therapy for the children in the special classes. Because of the shortage of staff, it has been impossible to be of much help to the schools in this program.

Bear in mind that this help has been directed only to those children with physical disabilities, and no attempt has been made to assist those with mental disabilities.

There is another group of severely handicapped children that has not been recognized in the Federal program, nor in many States.

That is the custodial-type child. There are a great many of these children who are so severely handicapped, both physically and mentally, that they can never compete in society.

In the State of Alabama there are several private groups who have established custodial homes. In these homes they not only care for the children, but they give as much therapy and training as the child is capable of absorbing.

Several years ago the legislature in Alabama appropriated a small amount to serve these children. The crippled children's service has worked in cooperation with these privately owned homes, and has kept about 15 to 25 children in there at all times, rotating these children every 3, 6 months. The reason for this rotation is shortage of funds and the number of children needing this service. Around 750 children have been served in this program since this first allocation was made by the legislature.

The Spastic Aid of Alabama, in Birmingham, has cared for about 600 children. They have cooperated with the State service by bearing part of the cost of a great number of these children.

It is our belief that this program should be recognized by the Federal Government and this service be considered along with other crippling conditions, and that sufficient Federal funds be allocated to care for this extra group of crippled children. Parents who have a custodial-type child need relief from the constant 24-hours-a-day care that is necessary. Where the family cannot afford to pay for the care, resources must be sought elsewhere. If a child can be placed in an institution, even on a temporary basis, he is given training to his fullest capacity in caring for his personal needs. This in itself relieves the family somewhat when he returns home.

We appreciate the opportunity of appearing before this subcommittee, and we hope that you will consider these problems seriously and sympathetically.

Mr. ELLIOTT. Thank you very much.

Are there any questions?

If not, at this juncture I want to recognize some of our friends who are visiting here today. I note Mr. Clyde Blackwood, superintendent of education of Blount County, is here.

Mr. Blackwood, would you stand?

Thank you, sir.

I note that Mr. Dwight Murfree, the principal of the Appalachian High School, is here.

We are happy to have you.

Mrs. Jewell Davis, the tax assessor in this county, is in our audience. Former State Senator Allen is also present.

I also note Clarence Franklin and Benny Fine of Cordova, Ala.

Let me say to all of you that we are happy to have you visit with us this morning.

Mr. ELLIOTT. Our next witness is Mr. O. F. Wise, director, Rehabilitation and Crippled Children Division, Alabama State Department of Education, Montgomery, Ala.

Mr. Wise is a long-time, able, and wise head of the vocational forces in this State, the vocational rehabilitation professional people. Just a year or two ago he was president of the American Vocational Association.

We are happy to have you, Mr. Wise, and look forward to your testimony.

I have noted that anything Mr. Wise does is always very thoroughly done. We are happy to have this privilege of hearing you.

STATEMENT OF O. F. WISE, DIRECTOR, DIVISION OF VOCATIONAL REHABILITATION AND CRIPPLED CHILDREN SERVICES, STATE OF ALABAMA, MONTGOMERY, ALA.

Mr. WISE. Thank you, Mr. Chairman.

Congressmen, needless to say, I am delighted not only to be here but to know that these hearings are going on in our State, in our Southland.

I believe historically our Southland has been rather vigorous in its efforts to promote the vocational rehabilitation of our disabled people.

I am pleased to have this opportunity to testify relating to rehabilitation aspects. As you mentioned, I am the director of the service for children and adults, and, therefore, we concern ourselves with the rehabilitation of children, even though it may not be vocational in nature but primarily physical restoration, as you just heard Mr. Bagley mention.

Today it is my purpose to speak primarily on the provisions of pending legislation as it relates to aspects of the program in Alabama. We have not only concerned ourselves with the physical rehabilitation of crippled children but the vocational rehabilitation program of adults, including the blind.

I am here with the approval of the executive office of our State board, the State superintendent of education, and whatever I say he has reviewed with me and is in accord.

We want to call particular attention to your bill H.R. 3465. We think that this bill and its Senate counterpart have been reviewed fairly well by lay leaders in our State who are interested in the rehabilitation of the disabled, top personnel of government and private agencies concerned with disabled people, as well as those of us who are within our own rehabilitation department.

I certainly approve the entire provisions of the bill H.R. 3465. We think that it rounds out the program of service to our State rehabilitation program, if enacted, in meeting the responsibility and providing service to all types of disabled people, including the severely disabled.

You will remember Mr. Benford's testimony relating to numbers. Not only did we have a backlog of known names of some 10,500 people on our rolls, but there are many others that are in a sense cataloged that we know of that we have not had the opportunity yet to see, and that group, as well as the 10,000 backlog, is what we are concerned with.

We have, as you may be aware, the responsibility for making the disability determination under agreement with the Bureau of Old Age Survivors Insurance. The section of the Social Security Act that made this provision provided that such applicants for disability determination would be referred for rehabilitation.

There are many thousands of those people that we have not been able to work into from the standpoint of evaluation to determine whether they could be vocationally rehabilitated or not. We have

agreements with our State welfare department whereby applicants for permanent and total disability benefits will be reviewed by vocational rehabilitation personnel for pensions during their application period. There are more than 12,000 recipients of this type under this category of public assistance in Alabama.

We are not proposing what number could be rehabilitated out of this group, because we have no facilities whereby we could make the evaluation and determination. I am sure, if we did have those, without other additional facilities, we would be rendering whatever service we could render. I must say that many of them would be greatly improved to a point, and they may be able to take care of themselves. However, they would not be able to be fully vocationally rehabilitated as we refer to the clients of today, following services whereby they returned to remunerative employment.

Vocational rehabilitation and the State hospital for the mentally ill have worked out an agreement which provides for the patients of the hospital who may possibly be returned to society will be placed in foster homes, as patients of the hospital, on furlough. This is for trial rehabilitation.

Procedures have been established to carry out the agreement, but facilities are not available to meet the needs.

Our experience has indicated that community rehabilitation facilities can contribute greatly to the rehabilitation of these people. The State educational program has a fairly new, essential education program. Teacher allotments made by the department of education to local school systems are made for special classes. Working arrangements between the exceptional education and vocational rehabilitation provides for the upper-age group in these classes to be evaluated for possible rehabilitation potential. These classes are made up largely of mentally retarded, and reference has been made earlier to the large numbers that we have in this category.

The amount of active training that so many of these benefit from are soon exhausted. The next steps are adjustments to work and so forth, similar services which can best be furnished in established facilities for that purpose.

There are vast numbers that we have actually had no inroads into, nor do we know what the number is. We have no normal agreements with groups relating to the cardiac, the arthritic, and others. We have formal arrangements or possibilities with hospitals for the tuberculars whereby those people can be returned.

But the answer is not a few more vocational rehabilitation counselors. We think that specialized facilities must be established with personnel capable of carrying out evaluation services at the first step.

So far in this State we have had some experience, as has been referred to earlier, with establishing some types of facilities. You heard of the establishment of the facility for the blind.

I could not resist it here, Mr. Elliott, giving or illustrating something with reference to the establishment of a workshop in your own hometown.

We had known for many years that rehabilitation facilities were needed which would include a rehabilitation workshop in Jasper or in that vicinity. This city is in the heart of the coal mining district,

and the problems of rehabilitating large numbers of disabled miners that we had known had been impossible.

In 1958 the local chapter of the Alabama Society for Crippled Children and Adults, along with another private organization, Industrial Missions, Inc., offered the first floor of a downtown building rent free for 5 years. The space was remodeled to meet the minimum requirements, and the rehabilitation center was opened about January 1, 1959. Some 10 or 12 severely disabled people can be served in this little facility at one time. The emphasis is on evaluation and training. However, some articles could be produced there by those who could work.

As fine as the gesture was on the part of the owner of the building, and as successful as is the small program that is being carried on at this time, it by no means meets the needs of the disabled in that area. Instead of making plans based on needs of the disabled, we were forced to plan for the best program possible with the space that was available.

Under the provisions of the bills under consideration now, a district committee could have been set up, operating a program offered to the people, and no doubt a building could have been constructed to meet the needs of the severely disabled in the area. There is a strong possibility in my opinion yet that this will come about in the event that the provisions of H.R. 3465 are met.

Another instance is in Montgomery. The local chapter of crippled children and adults and vocational rehabilitation joined together to form a workshop in an old warehouse building about 4 years ago. The facility today is in a very unsatisfactory location and in very poorly adapted space. The need for a larger workshop and facility for evaluation is urgent. The scope of the program could be increased to include the need of both physical and vocational evaluation service. This is a point where I feel that the three provisions of this proposed bill would have a common meeting ground: Your evaluation, facilities to carry out the evaluation as well as services, and at such times as those people will come before us that cannot be fully rehabilitated from the vocational standpoint, they can be returned to active, socially well-adjusted living, and people who can take care of their demands for daily living.

There are so many scopes of the program of dealing with disabilities that we could go into many aspects. However, I am sure that we will have a wrap-up of this before the day is over.

I would like to close by saying that we certainly feel that your efforts are pointed in the right direction. We think that by removing some of the restrictions as to the people that we can accept for vocational evaluation, some of the restrictions that can be removed for community participation in making these facilities possible, will be a long step forward in our total problem, in our meeting the total problem of the disabled, as we view it, from a rehabilitation standpoint.

Thank you very much, sir.

Mr. ELLIOTT. Thank you very much, Mr. Wise.

Are there any questions?

If not, let me say that I feel certain that your testimony will be very helpful to us in formulating legislation that this committee will soon consider.

(Mr. Wise's prepared statement follows:)

STATEMENT OF O. F. WISE, DIRECTOR, DIVISION OF VOCATIONAL REHABILITATION
AND CRIPPLED CHILDREN SERVICES, STATE OF ALABAMA

Mr. Chairman and members of the committee, my name is O. F. Wise. I am pleased to have the opportunity to appear before this committee to give testimony relating to rehabilitation. I am director of vocational rehabilitation in the State Department of Education of Alabama. We have vocational rehabilitation services and services to crippled children within my division in Alabama. This provides for a concern for the rehabilitation of children, as well as adults. However, today my purpose is to speak of the vocational rehabilitation aspects of the program in Alabama, which, as you know, deals with adults who have physical and mental disabilities, including the blind. I am here with the approval of the executive officer of the board of education and will present the attitude of our State administration in connection with certain aspects of legislation under consideration. My statements are directed primarily to the provisions of H.R. 3465.

This bill and its Senate counterpart have been reviewed by lay leaders interested in the rehabilitation of the disabled, top personnel of some private and public agencies, other professional people, and those of us primarily concerned with rehabilitation in my own department. I certainly approve the entire provisions of the proposed legislation and I do not know of anyone who is in disagreement with me. It appears to us in Alabama that all provisions of H.R. 3465 are necessary to round out the program of services of the State vocational rehabilitation program in meeting its responsibilities in providing services to all types of disabled people, including severely disabled individuals.

While I fully endorse all titles of these bills, it is my purpose first to talk specifically about title III, which relates to workshops and other rehabilitation facilities. The provisions of this title clearly relate to the provisions of title II relating to independent living services and title IV, which relates to improved evaluation services. We have had some experience in Alabama in developing rehabilitation workshops and facilities under a cooperative effort with public agencies and institutions and private nonprofit organizations. I think we know what these facilities can mean to severely disabled individuals, both for a proper evaluation of their condition and in providing effective treatment of their disabilities. In addition to this, we also use rehabilitation workshops as a means of employment while a disabled individual is in the process of preparation for competitive work or working for pay under a supervised situation on a continuing basis. We have worked with public trade schools in developing vocational evaluation facilities, with the university medical center and Mobile General Hospital in providing physical evaluation and treatment facilities, with the State institution for the deaf and blind in setting up adjustment and vocational training facilities and with local chapters of the Alabama Society for Crippled Children and Adults in establishing training and productive work centers. There is a cooperative development in Birmingham where a special workshop committee was set up. These developments have been on a very small scale with great limitations under present provisions of the law and in no way meet the total needs in providing rehabilitation services to severely handicapped individuals.

To best illustrate what title III of these bills will mean to Alabama, I will describe some specific workshop and facility developments and how they are failing to meet the need under Public Law 565, but with the provisions of these bills, I feel definitely that these workshops and facilities can make a greater contribution to the needs of the disabled.

About 7 years ago our State rehabilitation program became very much concerned with some special disability groups that had been previously neglected in our rehabilitation effort; included in this group was epileptics. Our prime effort being to return these disabled people to employment, we soon found that all seizures could not be completely controlled for all epileptics. The epileptic league did not have extensive financing; therefore, we looked for an existing building that could be secured to carry on the program that had been jointly

outlined. There was an unused part of a building which was owned by the crippled children's clinic and hospital in which the local rehabilitation and crippled children's service offices were located. With the cooperation of the owners, some renovation was made and equipment installed. We were able to provide rehabilitation services in the facility to six or eight clients with epilepsy at any one time. Soon thereafter other disability groups were applying for services offered by this facility. A local committee was set up composed of interested citizens who helped in getting more adequate space to carry on the activities. We could not consider a new building no matter how desirable it might have been because of restrictions contained in Public Law 565, which state in brief that Federal funds are not available for construction of a building. Neither could the local group finance the construction of the building.

The only thing that saved us in this situation was the availability of an abandoned workshop for the blind that was under the trusteeship of the community chest in Birmingham. The workshop board, the coordinating council of social agencies, the community chest, as well as vocational rehabilitation personnel, joined together in renovating and adapting the space for workshop and facility purposes. It is proving a wonderful asset toward the rehabilitation of the blind and severely disabled in this community. However, it is inadequate and if provisions of these bills become law, there is every reason to believe that the additional facilities that are so urgently needed in Birmingham can be developed.

In Montgomery the local chapters of the society for crippled children and adults and the vocational rehabilitation program joined together in establishing a small workshop in an old warehouse building about 4 years ago. The facility today is in its third unsatisfactory location and in poorly adapted space. It is a splendid program, but it is in a position to serve only a few people. The need for a large workshop facility and work evaluation program is urgent. The scope of the program should be increased to include the need for both physical and vocational evaluation services. This is a point whereby provisions of titles III and IV of H.R. 3465 would become closely related. The local society and other community group interests can be pooled to provide matching funds under the provisions of these bills and make possible much needed services to the disabled in this area. It is impossible to expect that the community will be able to take the responsibility for the entire cost of constructing a building.

The State society for crippled children and adults has established a Montgomery Area Rehabilitation Committee looking toward the possibility of establishing a physical and vocational rehabilitation facility in Montgomery. This private agency has been given 3 acres of land adjoining a proposed Baptist Hospital site. At this time about \$100,000 has been raised. The schematic drawings of their facility indicates a \$600,000 investment. Provisions of these bills will make it possible for this much needed rehabilitation facility to become a reality at an early date. Without these provisions, we can expect to wait many years before such development becomes possible, if at all.

In Jasper, Ala., we have known for many years that a rehabilitation facility was needed which would include a rehabilitation workshop. This city is in the heart of the coal mining district and the problem of rehabilitating the large number of disabled miners that we know has been impossible. In 1958 the local chapter of the society for crippled children and adults along with another private organization, Industrial Missions, Inc., offered the first floor of a downtown building rent free for 5 years. The space was remodeled to meet the minimum requirements and the rehabilitation center was opened about January 1, 1959. Some 10 or 12 severely disabled people can be served at one time. The emphasis is on evaluation and training; however, some articles are produced for which the disabled workers are paid.

As fine as the gesture was on the part of the owner of the building and as successful as is the small program that is being carried on at this time, it by no means meets the needs of the disabled in the Jasper area. Instead of making plans based on needs of the disabled, we were forced to plan for the best program possible with the space available. Under the provisions of these bills, a district committee could have been set up, a capital outlay program offered to the people, and a building could have been constructed to meet the needs of the severely disabled in this area. There is a strong possibility that this can yet come about if these bills are enacted with the workshop and rehabilitation provisions set forth in title III.

We have joined with many community groups in developing workshops and other facilities and have found that securing space and equipment have presented

problems, but the greatest problem we have had to face has been providing initial staff. I, therefore, feel that provisions should be made for payment of initial staff as these bills would do. We have tried out initial staffing on a 1-year basis as provided for in Public Law 565, in establishing facilities, and found it inadequate. Certainly vocational rehabilitation funds for initial staffing should be available over a longer period of time; the 2-year provision of these bills should meet the need.

In order to provide rehabilitation services to the vast number of disabled people who are known to our vocational rehabilitation agency, many more rehabilitation facilities are needed. The types of rehabilitation facilities needed include comprehensive centers, sheltered workshops, halfway houses, occupational centers for the mentally retarded and emotionally disturbed, and a number of variations of all of these.

In Alabama we have had thousands of referrals from the Bureau of Old-Age and Survivors Insurance as a result of amendments to the Social Security Act. These referrals, made in connection with the disability determinations program carried out by the State vocational rehabilitation agency, are required by law.

We have an agreement with our State welfare agency whereby applicants for permanent and total disability benefits will be reviewed for vocational rehabilitation potential in connection with their application for public assistance. There are more than 12,000 recipients under this category of public assistance in Alabama at the present time.

Vocational rehabilitation and the State hospital for the mentally ill have a working agreement which provides for patients of the hospital who may possibly be returned to society through vocational rehabilitation, to be placed in foster homes as patients of the hospital on furlough, for trial in rehabilitation. Procedures have been established to carry out the agreement; facilities are not available to meet these needs. Our experience indicates that community rehabilitation facilities and workshops can contribute greatly to the rehabilitation of these mentally ill people.

The State educational program has a fairly new exceptional education program. Teacher unit allotments are made by the department of education to the local school system for special classes. A working arrangement between the exceptional education unit and vocational rehabilitation provides for the upper aged youth of these classes to be evaluated for possibly rehabilitation potential. The classes are made up largely of the mentally retarded. The amount of academic training from which they can benefit is soon exhausted. The next step is occupational tryouts, adjustment to work situations, and similar services which can be best furnished in rehabilitation workshops and facilities.

There are vast numbers of disabled groups for whom we have no formal procedure in handling. This includes the large number of people who have cardiac conditions and those with arthritis.

A more formal working arrangement should be established with the hospitals for the tuberculous whereby rehabilitation facilities could be established for the patient to regain work tolerance and habits as he regains his health.

I would like to conclude my statement by saying that the establishment of a rehabilitation workshop and other facilities is a necessary adjunct in carrying out good vocational diagnostic procedures with large numbers of disabled people with extraordinary problems. Rehabilitation facilities should be developed to provide clinical findings and the therapies required in returning chronically ill patients to an independent living status. They should further be developed as a reasonable way in which vocational adjustment, prevocational and vocational training can be offered and to provide limited work for pay to those who might be expected to require supervised and sheltered conditions for their livelihood.

Mr. ELLIOTT. I notice that Dr. M. S. Whiteside, of Cullman, is in our audience.

Thank you for coming, Dr. Whiteside.

Our next witness this morning is Mrs. Alpha Brown, consultant, program for exceptional children, Alabama State Department of Education, Montgomery, Ala.

STATEMENT OF MRS. ALPHA BROWN, CONSULTANT, PROGRAM FOR
EXCEPTIONAL CHILDREN, ALABAMA STATE DEPARTMENT OF
EDUCATION, MONTGOMERY, ALA.

Mrs. BROWN. Mr. Chairman and members of the committee, I certainly appreciate your interest in this program and the opportunity to present our needs to you.

I wish, first of all, to say that I am interested in the education of all children, but I do feel that we should provide the specialized additional program which is needed to aid pupils to become self-respecting, self-supporting, socially responsible, and informed adult citizens despite a handicap or exceptional condition.

The State superintendent of education, the State board of education, and the State Committee on the Education of Exceptional Children are very interested in this program and are giving time and energy in helping to promote, plan, and develop a good program of special education in our State. Many organizations and groups have worked cooperatively toward this goal. A variety of problems and needs have been encountered.

Let us consider, first, the number of exceptional children. Most estimates give 10-12 children out of every 100 in need of some special service and special educational program. In Alabama, services are being provided in a limited way for roughly 6 percent of the estimated exceptional children. Therefore, one of our long-range needs is to provide services to these exceptional children who are not receiving any. Many additional classes will be needed to provide services, facilities, and educational programs for the exceptional children in Alabama.

To meet the needs of these children in this program now and in the future, adequately trained personnel is needed. This trained personnel should include classroom teachers; principals; superintendents with inservice training; supervisors in the various areas of disability; physical, occupational, and speech therapists; nurses; medical social workers; guidance personnel; and vocational rehabilitation counselors. There is a critical shortage of personnel in all of these categories.

The teacher shortage is critical in all areas of special education. In Alabama, some of our teachers working in special classes have no special training. The extent of training with the other teachers ranges from 2 hours to a master's degree in special education, with very few teachers in the upper level of training.

A chart is attached giving hours of training.

(The chart and 1959-60 program follow:)

Number of semester hours of training of teachers of exceptional children

White teachers :		<i>Number of semester hours</i>	Negro teachers :		<i>Number of semester hours</i>
No. of teachers (254) :			No. of teachers (51) :		
170	-----	0	29	-----	0
10	-----	2	3	-----	2
5	-----	3	1	-----	3
2	-----	4	7	-----	6
25	-----	6	4	-----	8
4	-----	8	3	-----	9
1	-----	9	1	-----	12
1	-----	10	1	-----	13
23	-----	12	1	-----	14
4	-----	18	1	-----	36
2	-----	24			
1	-----	30			
3	-----	32			
2	-----	38			
1	-----	40			

1959-60 program for exceptional children

Total number of teachers employed:		
White	-----	254
Negro	-----	51
Total	-----	305
Approximate number of children enrolled in these classes:		
Mentally retarded	-----	3,700
Physically handicapped	-----	900
Total	-----	4,600
Approximate transportation cost	-----	\$38,500
Approximate number of schools housing classes	-----	216
Number of school systems operating classes:		
County	-----	45
City	-----	32
Total	-----	77

NOTE.—3 additional county systems pay transportation costs for children to attend classes in another school system.

Breakdown of classes by type handicap

WHITE

Systems	Physical	Home-bound	Hospital	Mental	Socially maladjusted	Total
Counties.....	11	14	1	119	0	145
Cities.....	36	1	5	66	1	109
State.....	1 47	15	6	185	1	254

NEGRO

Counties.....	0	2	2	23	0	27
Cities.....	4	0	1	18	1	24
State.....	2 4	2	3	41	1	51
Grand total.....	51	17	9	226	2	305

¹ Breakdown of these 47 classes:

Speech therapy.....	6
Hard of hearing and speech.....	11
Partially seeing.....	1
Other physical handicaps (including cerebral palsy and multiple handicaps).....	29
Total.....	47

² Breakdown of these 4 classes:

Hard of hearing and speech.....	1
Other physical handicaps (including cerebral palsy and multiple handicaps).....	3
Total.....	4

Mrs. BROWN. Through training we feel that the teacher will better understand (1) the child's problem; (2) what his educational program should be; (3) how to guide and present the program; and (4) the expected outcomes of each specific program for each special type of handicapping and exceptional condition. A particular effort must be made to provide an appropriate program for each pupil enrolled in each class. It is realized by all that specialized services cannot be provided with nonspecialized personnel.

We must not permit these special classes to become places where children who do not fit in the regular classroom are stationed. There must be a particular reason for establishing each class, each facility, each service, each piece of equipment, and special instructional materials. Exceptional children should be placed in a program designed and equipped to cope with their specific type of disability.

The placement of a pupil in a program not planned for one in his condition might be harmful to him and also prevent all the other pupils from progressing as they should. Therefore, attention must be called to the vital need for well-trained personnel who do the screening, diagnosing, and evaluation of these pupils which determine their eligibility for special services and special classes.

Again, there is an enormous shortage of school psychologists, psychiatrists, medical social workers, and others who play an important part in this phase of the program.

More staff is needed at the State level. With 300 units, 1 person cannot adequately meet the needs of the program. Supervisors in the various areas of exceptionality are needed at the local level to assist teachers on the job with their problems.

No school system in Alabama employs a supervisor of special education or a physical or occupational therapist. A limited number of speech therapists are employed. There are two reasons for this: Lack of funds and lack of available personnel.

Special attention should be directed to children of high school age. Many drop out here. Some dropouts are due to severe emotional upsets which frequently occur during the adolescent years because of lack of social acceptance and limitations in the ability to participate in the activities of this age group.

Also, the program must be planned to bridge the gap between special classes and job placement. The rehabilitation and crippled children's service and special education work very closely together in Alabama. This service gives us all the help they can, but limited personnel prevents sufficient help in these areas.

All children need guidance, and particularly do the exceptional children. Guidance, to be effective, is a continuous process that starts when the child first enters school and does not stop until the day he leaves school. In many instances it may follow for a time after he leaves school.

The function of guidance is to help the child understand himself in relation to his needs and the demands of his environment so that he may live as full and effective a life as possible today as well as in the future.

Many people will be involved in the guidance of exceptional children. In working with these children, all of the services for normal children are needed plus services for the additional problems involved in the exceptionality.

These children must be helped in accepting their limitations, to be realistic about their vocational potentials. They must be given help in securing social acceptance. The people responsible for guidance of exceptional children should provide them with necessary information concerning occupational, social, and general environmental requirements. Parents must be given help in accepting their handicapped child and the limitations involved, to be realistic about what can be done for him and what he can ultimately attain. Help should be given if the parents are overprotecting or rejecting the child. Again, trained personnel is needed in this field.

HOUSING NEEDS

Many communities attempt to operate special classes or provide special services in inadequate buildings or quarters not designed for school purposes. In addition, many communities are presently planning and building new school plants without giving consideration to facilities for the education of exceptional children. Special education needs, both present and future, should be considered before building. The facilities for special education should be neither better nor worse than those provided for the regular program. However, there are some facilities and some special equipment that must be provided if the objectives of the program are to be accomplished. What is needed will depend upon the specific type of exceptionality to be served and upon the background of the teacher, therapist, and other personnel working with the children.

Funds for transportation are needed. Numbers of exceptional children in rural areas are denied the needed training and services due to lack of transportation to bring them into centers where programs are available. More transportation is needed to take children to and from treatment centers.

Our law has been judged as outstanding by specialists in this field throughout the country. It is liberal and flexible in every respect and makes it possible for the State board of education to work with local boards of education in providing many of the services needed by exceptional children and youth. Not enough financial support is provided at the present time to develop all of the facets of the program in a satisfactory manner. We hope that our program will be such that, through special education, most of our children will be employed instead of standing in the line of the nonemployed and the unemployable.

We feel that the Federal Government could assist in this program by (1) providing funds for the training of needed personnel by increasing the benefits under Public Law 85-926. Presently there are five requests on my desk. Little publicity has been given to it due to the fact that Alabama's goal is filled. In providing funds for the training of needed personnel, the Federal Government could assist:

(1) By providing a training program for all personnel working with exceptional children similar to that now being provided for teachers in the field of guidance, science, mathematics, and modern foreign languages.

(2) By providing financial assistance to the various institutions involved in these training programs.

(3) By providing additional funds for transportation.

(4) By providing additional funds for equipment.

(5) By providing additional funds for improvement of facilities.

(6) By providing additional funds for instructional materials.

With this help, I believe the program of special education would move forward soundly and effectively.

Mr. ELLIOTT. Mrs. Green desires to ask you a question.

Mrs. GREEN. Mrs. Brown, for a day and a half we have heard witnesses testify as to the needs of more personnel, more adequately trained personnel, and the lack of funds. Here in Alabama, have you given real consideration to how much you would actually need if you were to undertake an adequate program, how many personnel you now have, and how many you would really need if you did the job?

Mrs. BROWN. I think that would be a longtime plan. We would have to plan a few additional units each year. We should go back and train these teachers who do not have adequate training that are working with us now.

We have 305 classes now for exceptional children, and I believe there are 170 white teachers that lack any training. I believe there are about 20 Negro teachers that lack training. The chart on my statement refers to that.

Mrs. GREEN. Have you made any estimate of how much money it would take in this one State?

Mrs. BROWN. No.

Mrs. GREEN. This is the thing that runs through my mind: We hear over and over that we must have more personnel, we must have more funds. First of all, do you have funds for the normal children?

Mrs. BROWN. Yes.

Mrs. GREEN. Do you have a program that you consider adequate for all of the normal children in Alabama?

Mrs. BROWN. Our teachers are not adequately trained in the normal field. We have many teachers working with our regular children that are not adequately trained in Alabama.

Mrs. GREEN. How are you going to get more teachers?

Mrs. BROWN. I think we are going to have to begin a recruitment program. Probably at the last year in high school we will let the people know about these children, let them observe some of our special classes, and let them know in their early college training, to let them know about the program; do something in the way of orientation, and try to recruit more teachers to take this training.

We do have regular teachers who are interested in this field, and we could urge them to take more training.

Mrs. GREEN. This sounds good.

Yesterday one gentleman testified that the maximum salary that a psychiatric social worker, which would be up on the scale, could expect after years of service was \$6,200. I believe that was the testimony.

This person that is graduating from high school and going into college looks at the bricklayer, either here or in some other place, who makes more than this. How are you going to recruit the personnel to do the dedicated and inspired task of working with the exceptional children?

Mrs. BROWN. There are some people who really want to do that. Sometimes there is a parental background where they encourage them to go into teaching.

I think one way we could do it is to raise the salaries of teachers. That might bring them in. I think that is one thing. We all think of economic security, and we want that future for ourselves. But I think we are improving in that area.

I could not tell you, though, how much it would take. It is a difficult job. We are so short of teachers; but that is why. We have not been able to get them into the program. I think part of it has been due to the lack of financial security.

Mr. DANIELS. When you say financial security do you mean lack of adequate salary?

Mrs. BROWN. Yes.

Mr. DANIELS. Does the the State of Alabama have a minimum salary for teachers?

Mrs. BROWN. The State makes a salary allotment due to training, and then each system sets up its own salary scale.

Mr. DANIELS. When you say due to training do you mean having a degree?

Mrs. BROWN. That is right.

Mr. DANIELS. Is the ceiling placed on a salary of a teacher having any of those degrees?

Mrs. BROWN. Not with a local system. The State department allocates according to training, and each school system may set up a salary scale they feel they can support.

Mr. DANIELS. Therefore, from one county or parish to another the salary may differ?

Mrs. BROWN. That is right.

Mrs. GREEN. How much is the State allotment?

Mrs. BROWN. It ranges from \$4,200, the salary for a master's degree.

Mrs. GREEN. That the State provides?

Mrs. BROWN. The State allots that much.

Mrs. GREEN. How much do they provide of the \$4,200?

Mrs. BROWN. For a master's degree they would allocate \$4,200?

Mrs. GREEN. And then the local district would add to that?

Mrs. BROWN. They could add more if they wanted to. Some of our cities add \$300 or \$400 a year to that.

Mr. GIAIMO. You spoke of the shortage of personnel and the need for Federal funds. Is the State of Alabama or any of the States with which you are familiar doing anything to get additional funds into this program?

Mrs. BROWN. Each year there is an effort made with the legislature to do that. We did get quite an increase in appropriations this year, but there is danger of a proration because some of the money allocated for education may not come in in the amount that it was allotted for.

Mr. GIAIMO. So that up until this time at least there has not been an increase in the amount of appropriations?

Mrs. BROWN. Yes, each 2 years we have had some increase.

Mr. GIAIMO. Has it been adequate?

Mrs. BROWN. No.

Mr. GIAIMO. Is the problem, then, the shortage of local funds or State funds?

Mrs. BROWN. Well, we need both at both levels. It seems that our State provides more from the State level than other States, than many other States. So we need both more from the State level and from the local level. But that is going to be a problem of education and of getting people, the public in general, more interested in going along with better salaries for teachers.

Mr. GIAIMO. Along the lines of getting the public interested, I think that is one of the big problems in this whole field of the handicapped, to get more public awareness. At such time as we do I think we will have progressed a great deal toward solving this problem.

Have you noticed any increase in Alabama in public awareness of this problem?

Mrs. BROWN. In some areas I would say so. I mean in some communities. And in others I would say not. But where we have a real good teacher or teachers, they usually sell the program. They are one of the best agents we have for selling the program, a good special education class doing more to sell the program than anything else that can be done.

Mr. GIAIMO. That is true, but that is usually the exceptional case, is it not, or unusual?

Mrs. BROWN. Of course, many of our teachers do not have the ability to sell the class.

Again, I think if they were trained, they would do a better job in selling the class.

MR. GIAIMO. One of the concerns that I have had in the northeastern States has been a lack, I think, of public awareness, or of sufficient public awareness.

MRS. BROWN. It is a lack of understanding of the program. I think that is one of our major problems.

In the first place, in Alabama it is a new program. I think that is partly it. They ask me, "What are you going to do with these children when you get them in your special class? What is the ultimate outcome?"

I think that is a good question from the lay person. We have to work towards that. I think there are many ways we could do that: Through appearing before civic clubs; through using some of the few films available, and through having newspaper publicity. That is a job that really needs to be done here, and, I think, maybe, in other States, too.

MR. GIAIMO. But has a start been made toward doing that?

MRS. BROWN. Yes. Our PTA, our State PTA is very interested in this program, and on their two regional programs they have had the program for exceptional children.

Many civic clubs are asking various people to come in and discuss this program. So I think there is an increasing awareness. But, still, it is not at all complete.

MR. GIAIMO. You do not feel that this is unique to any one State?

MRS. BROWN. No, I do not.

MR. GIAIMO. I agree with you. I think it is universally so throughout the country.

MRS. GREEN. You mentioned some inservice training. If I understood you correctly, you suggested inservice training for principals and supervisors.

MRS. BROWN. Yes.

MRS. GREEN. Is there such a program?

MRS. BROWN. There are many inservice training programs in Alabama. A few of the systems include a program dealing with the program for exceptional children. But so often it is only that we have one or two teachers in a system for this program and there are not enough for a group.

But there are some inservice programs this year where teachers have asked various people to come in and serve as consultants to a group of regular teachers on how to work with the exceptional child in their classroom, which I think is a good chance for some inservice program.

Then I think we need really to work with superintendents and principals. I think they need an inservice type of training. After all, they are going to provide the main leadership in this program.

If a principal is not for the program it is not very wise to put a class in his building. Too, some of the regular teachers even do not understand this program. So we have a big job of educating the public in this program in our State.

MR. ELLIOTT. Thank you very much.

I want to recognize the presence of Mr. Owen Williams, the chairman of the Republican Party of Cullman County. Also I recognize Mr. Newt Rains, who tells me that he will be a candidate for one of Alabama's delegates to the National Democratic Convention.

I also want to recognize G. S. Smith, a former assistant superintendent of education of this county, and a former superintendent of education of Lamar County, another county of our district.

Mr. Smith, we are happy to have you, sir.

I also recognize Mr. Thurmond Guthrie, the veterans' service officer for Cullman County. And Mr. Bryce Davis, a former member of the legislature of this county.

I had thought by this time that we would have a recess. However, while we wait a few minutes for the time to arrive, we will ask Mr. Craig Mills, assistant director of the Division of Vocational Rehabilitation of the Florida State Department of Education, to proceed.

STATEMENT OF CRAIG MILLS, ASSISTANT DIRECTOR, DIVISION OF VOCATIONAL REHABILITATION, FLORIDA STATE DEPARTMENT OF EDUCATION, TALLAHASSEE, FLA.

MR. MILLS. I am Craig Mills, assistant director of vocational administration in the State of Florida. I represent Mr. Claude M. Andrews, the director of vocational rehabilitation in Florida, who was invited to appear. Unfortunately, he had previously made commitments which have kept him from being here, and he has asked me to attend in his place.

We wish to express our appreciation to you and to the committee for this opportunity. I also bring the greetings of Superintendent Thomas N. Bailey of the department of education in Florida.

As we sat through the hearings yesterday and today, and as we enjoyed the opportunity to participate in the workshop in Atlanta on Monday and Tuesday, we heard a recurring theme of needs for personnel, facilities, training facilities, workshop facilities, and the need for research.

I think I can echo that our needs in Florida are similar to those expressed, and it is with some awe that we realize that so many of the things brought out in the study in the workshop on Monday and Tuesday were things that had already been provided for in some measure in H.R. 3465. This brings to our attention the fact that considerable foresight went into the preparation of that bill, and we would like to join those who have already testified in endorsing the provisions of H.R. 3465.

There are a few things that I think I might add that have not previously been brought out in testimony which would be of some significance to you.

As we have heard these accounts of needs one could almost become discouraged by the overwhelming task that seems to be before us in the field of disability, and with the relatively few resources which appear to be ours in the handling of this job. In doing this we would not want to leave the impression with you that the tools and the resources which have been given to us have not been effectively used, or that they have not been helpful. For instance, we have gained much from provisions in Public Law 565 under which we now operate in vocational rehabilitation, which are somewhat similar and are at least in harmony with many of the provisions contained in H.R. 3465. For instance, we have gained greatly by research and demonstration projects. We have gained greatly in our State by additions to facilities.

The inservice training program made possible under that law has been a substantial contribution to our staff. We have been aided greatly by orientation training, supervisory training, short-term programs on the fitting of prosthetic appliances, working with the deaf and hard of hearing. We have benefited vastly by the counselor training program which was instituted pursuant to that law.

Here in the southeastern region we have two such regional training programs, one of which is at the University of Florida, and one of which is at Vanderbilt University. We now have our own staff in Florida, 11 men who came from the training program set up pursuant to that law. This has been a tremendous boost to us in thoroughly training competent individuals who have been able to come on our staff without having to go through long periods of intensive inservice training, without having to consume the staff time of our trained staff members, and who have been able to get into production in a relatively short time.

We feel that the success shown in this type of provision under Public Law 565 bodes well for the future of the things recommended in H.R. 3465, and we commend to you and to the Congress the passage of this law.

I feel I should tell you that we feel our greatest need is still in the area of funds for facilities and diagnosis and evaluation.

Mr. Wise has testified to you on the impact of the working relationship that we have with social security and the Bureau of Old Age and Survivors Insurance. Through this relationship we have uncovered many thousands of disabled adults who have multiple, chronic disabling problems, who will require intensive evaluation and thorough appraisal. We have a real need in this area.

There are one or two other things in connection with provisions of H.R. 3465 which perhaps have not been emphasized in the past 2 days which I would like to bring to your attention.

We sometimes hear disparaging remarks being made regarding Federal interference. I want to tell you that, so far as we are concerned in Florida, we feel that the working relationship between the State division of vocational rehabilitation and the Federal Office of Vocational Rehabilitation is a model. We have received every cooperation and assistance possible from the Federal Office, and we feel that it is only right and reasonable that H.R. 3465 contain a provision asking for the administration of the independent living provisions through the Federal Office of Vocational Rehabilitation.

We feel also that it might be important to tell you that there is a readiness on the part of our State and many States to get into this new phase of work. We feel that there is an expression of opinion already in our State that vocational rehabilitation should handle this work and should be permitted to do rehabilitation for independent living. I believe it was brought out to you in testimony yesterday by Mr. Miller that Florida had already passed an independent living bill somewhat similar to H.R. 3465.

It has been reported unofficially that approximately 14 States in the country have such bills. While this would indicate a readiness on the part of the States, I think we should recognize also that there is a time lag, or will be a time lag following the passage of Federal legislation during which certain other States will have to propose

amendments to their State laws, or propose the enactment of enabling State legislation to permit them to take advantage of the Federal provisions.

For this reason it seems to us that our job in the passage of H.R. 3465 is even more urgent than ever before and makes it most important that it receive consideration this year.

We want to express our appreciation to you and to your committee for these long-range studies that have been made, for the opportunity to testify in behalf of this bill, and to urge that all possible action be taken on it in the Congress this year. We would also at the same time like to pledge you our support in being of assistance in any way that we can in accomplishing this task.

Thank you very much for this opportunity to be with you today.

Mr. ELLIOTT. Thank you, Mr. Mills.

Mrs. Green.

Mrs. GREEN. Do you see any advantages or disadvantages to having the rehabilitation for the blind a part of the vocational rehabilitation program in the State?

Mr. MILLS. I forgot to mention that.

In Florida, of course, rehabilitation for the blind is handled by a separate division, the Florida Council for the Blind. Our regular vocational rehabilitation program does not handle vocational rehabilitation for the blind.

We feel that in our State at least this is a distinct advantage. They have specially trained people in this capacity, and they do a most effective job.

In those States where rehabilitation for the blind, as well as rehabilitation for other disabilities, have traditionally been handled by one agency, I am not so sure there would be the same advantages accruing if the separation of functions were made now.

Mrs. GREEN. What are the reasons for having a separate agency for the blind that would not hold for all the other areas?

Mr. MILLS. In those areas where considerable training has been given to general rehabilitation personnel I think there would be some loss of past training effort, if a separation were now made. The avenue is of contact in local communities; the supervision procedures, the administrative procedures, might suffer some loss of motion and some loss of effectiveness in service, at least while the separation was being made. After a long-run period perhaps it would be more effective. This would be purely speculative on my part.

Mrs. GREEN. Is there more reason for having a special agency for the blind than for the deaf?

Mr. MILLS. Yes, I think there is.

People who work with the deaf closely might well present the argument that the problem of communication with the totally deaf would make even more reason for special work with a special agency or special workers with the deaf.

Since we do not have a special agency for work with the deaf, our men have generally been trained to work with the deaf and with the hard of hearing, and, while I feel that any agency which is doing work of this type would benefit by having some specialists on their staff who are well equipped to communicate with the totally deaf and who could act as consultants to counselors, there generally would be

no tremendous advantage in having an exclusive agency for the work with the deaf alone.

Mrs. GREEN. Thank you.

Mr. ELLIOTT. Thank you very much, Mr. Mills.

Dr. Stanley Ainsworth was to be our next witness, and he has written me a letter expressing the reason for his inability to attend.

Without objection, I will make Dr. Ainsworth's statement a part of the record. I might say that Dr. Ainsworth was with us yesterday and testified in another connection.

(The statement referred to follows:)

STATEMENT BY STANLEY AINSWORTH, PH. D., PROFESSOR OF SPEECH CORRECTION AND CHAIRMAN, PROGRAM FOR EXCEPTIONAL CHILDREN, UNIVERSITY OF GEORGIA, ATHENS, GA.; PRESIDENT, AMERICAN SPEECH AND HEARING ASSOCIATION

Mr. Elliott and members of the subcommittee, in presenting testimony to you concerning House Joint Resolution 494, I am doing so in several capacities. I have been active in the field of speech and hearing disorders for more than 20 years with an additional 5 years of general teaching. This experience has included public school teaching, public school speech therapy, clinical services for a crippled children's home, and activities in several university speech and hearing clinics. My duties have included advisory and consultant services to community speech and hearing clinics and rehabilitation centers, State and county programs, colleges, State departments of health, education, and vocational rehabilitation, the U.S. Office of Education and the U.S. Office of Vocational Rehabilitation. For the past 16 years, I have been training speech and hearing personnel and have assisted in the establishment of new training programs in three universities. My present work is concerned with the direction of a training program for speech correctionists and teachers of the mentally retarded and of the physically handicapped. Also, as president of the American Speech and Hearing Association, I shall try to represent the thinking of this whole profession as well as possible.

Before any comments about House Joint Resolution 494 can be made, it is important to present the context within which these opinions will be given. Any legislation which is designed to assist those with speech and hearing disorders must take into consideration the complexity of the professional field which is concerned with these handicaps. For instance, the professional people in this field offer a wide range of remedial and therapeutic services which have outlets in many job situations. These working situations differ in their emphasis and primary goals. A great many clinicians are found in public schools where the emphasis is on alleviating communication disorders as a vital contribution to the total education process; many others function in medically oriented centers concerned with the physical and mental rehabilitation of the individual. In this latter situation the clinician contributes to the communicative aspects of this rehabilitation. Other clinicians function in settings which have neither a medical nor an educational emphasis but concentrate on the communicative disorders apart from any other professional or institutional emphasis. Still others serve in supervisory and consultant capacities in State, county, and city departments of education and health. Other clinicians may engage in private practice. In the process of helping individuals of all ages, from preschool to old age, the speech pathologists and audiologists not only apply distinctive diagnostic and therapeutic procedures but must relate effectively to many other therapeutic, educational, and professional disciplines in such a way as to bring about an effective improvement of the individual's communication. The specific nature of the disorder may vary considerably depending upon the type of problem, the age of the individual and his particular personal, social, and economic needs. It should be stressed that whatever an individual needs in regard to his communicative disorders, the changes that take place in him when he improves are the same regardless of the clinical setting within which he receives this treatment. Furthermore, the basic training for all clinicians is the same. Those who wish to work in certain job situations or at particular levels of professional activity should, of course, take additional training to equip themselves appropriately.

If we are to serve these individuals effectively and efficiently, we must encourage outlets for clinical services in as many job settings as possible. If this is not done there will be serious gaps in the help for different age levels and for some types of problems. A limitation of services to one type of clinical facility—such as educational, medical, rehabilitation or any similar designations—would prevent services to the other areas which are equally concerned with restoring the handicapped person to his highest level of personal, social, and economic potential.

There are some types of problems which are related to certain physical and psychological deviations but even these contain unique characteristics involving communication; there are other types of problems which are not specifically related to anomalies other than those within the area of communication itself. The procedures in diagnosing and treating all these individuals involve principles of learning but the speech and hearing clinicians does not function as the classroom teacher who is concerned with classrooms of children, academic content and skills, and general social adjustment. And although the speech and hearing clinician is concerned with "readjustment" of the individual, the necessity for focusing on all aspects of oral communication makes this work distinctly separate from the profession of clinical psychology. Those close relationship to principles of learning and the communicative readjustment of the individual demonstrates that the diagnosis and therapy conducted by the speech pathologist and audiologist are not primarily medical. Therefore, the speech pathologist and audiologist is most appropriately viewed as a member of an independent profession who provides diagnosis and remedial services in many settings. It is true, of course, basic research and understanding of certain of these communicative problems may involve many of the basic sciences and of psychology, medicine, sociology and rehabilitation, etc.

The kinds of complexities briefly outlined above increase the difficulty of providing legislation which will satisfy all levels and all areas of needs in this field. Any such legislation must be constructed in such a fashion as to retain the professional independence of speech pathologists and audiologists. It should not limit support of the field or imply restrictions of function to any one field such as education, medicine, psychology, or rehabilitation. The speech pathologist and audiologist relates to and contributes to all of these areas as well as providing services which are unique and independent of these areas.

These comments have not stressed the many and diverse needs in the field. I am sure that these have been covered amply by the people you have heard in your hearings these past 2 days as well as in materials which have been provided you previously. There is little question that the most critical needs involve the provision of adequate and sufficient personnel. Any attempt to meet this demand must involve some kind of assistance (1) for the students wishing to become speech and hearing clinicians, and (2) for the improvement and expansion of training programs. If the profession as a whole is to meet its responsibilities to the handicapped, it is obligated to support any legislation which will improve the quality and increase the number of personnel in the field and which will allow the members of the profession to retain their professional identity and independence as speech pathologists and audiologists.

House Joint Resolution 494 is a bill which aims directly at increasing and improving personnel and training programs. Therefore, the American Speech and Hearing Association has officially endorsed this bill. We believe that its passage would assist significantly in attracting more individuals into this field and in improving the quality and number of our training programs. It is true that this single bill does not attempt to meet all of the urgent needs in the field of speech and hearing disorders. It is doubtful if any omnibus bill would be provided which would supply the variety of support needed in this complex field which cuts across and participates with so many professions. Therefore, I would like to urge that this bill be supported as an important step in relieving the personal tragedies and incapacities resulting from speech and hearing disorders.

On behalf of the entire profession of speech and hearing, I wish to express my deep appreciation for giving me the opportunity to present this testimony.

Mr. ELLIOTT. Our next witness is Mrs. J. C. McMeen, southeastern director, National Association of Retarded Children, Columbia, S.C.

STATEMENT OF MRS. J. C. McMEEN, SOUTHEASTERN DIRECTOR,
NATIONAL ASSOCIATION OF RETARDED CHILDREN, COLUMBIA,
S.C.

Mrs. McMEEN. I dislike reading a paper, but, being a woman, I knew I could never condense it in the time allowed.

Mr. Chairman and distinguished members of this committee, having listened to the many qualified professional people testifying during this hearing, I consider it a real privilege to be allowed to speak on behalf of the mentally retarded and their families.

Not being a professional person, perhaps I should just file my own request to appear as an interested citizen before this important committee, and explain my particular interest in the field of mental retardation, a subject that is very near and very dear to my own heart.

I am the mother of a cerebral-palsy retarded child, and have had the pleasure of working in a voluntary capacity for the associations for retarded children on local, State, and National levels for the past 7 years.

When, during the workshop in Atlanta, parent groups were referred to as pressure groups, I had to stop and thank God that my own child was born during this era when so many parents of retarded children have finally stopped burying their heads in the sand and have stopped hiding their retarded children in back rooms, and are now seeking help for these forgotten children who have so long been neglected.

Much progress has been made in the field of mental retardation, particularly since the inception of the National Association for Retarded Children just 10 years ago. Yet we have barely scratched the surface in some areas in our attempts to help all of the mentally retarded.

As chairman of the national association's membership committee, I am proud to advise this committee that we now have over 700 units that are members of our national association. We are presently working with units all over our 50 States, the Territories, and with military installations overseas.

I wish that I could come before this committee today and simply request of it an appropriation to purchase a magic wand to wave over all the mentally retarded, to completely eliminate this tragic and heartbreaking condition that affects so many, some 5 million children and adults in our Nation. However, since there are still some things that money cannot buy, I would like to take this opportunity to thank you for the interest you have already shown toward helping the retarded to have the chance for a happy life, and the opportunity for learning that is supposed to be the right of every child.

Mr. ELLIOTT. Do you approve the bill that we passed a couple of years ago to provide training for teachers of the mentally retarded?

Mrs. McMEEN. We certainly do. It has been a big help.

Mr. ELLIOTT. It is proving to be a real help, and will prove to be a real help, will it not?

Mrs. McMEEN. We find it very good; yes.

With the mentally retarded rehabilitation or, rather, habilitation begins from the moment that parents know their child is retarded. Through early identification and evaluation, and with the proper

planning and coordination of services for our retardates we can expect higher performance on their part, leading to less dependency, thereby saving many tax dollars.

There is still a crying need for more and better diagnostic evaluation and followup service centers. Many of the ones we already have are restricted to certain age groups.

There is also a tremendous need for parent counseling, nursery and all-day care centers, more special classes both for the trainable and educable children, prevocational shops, sheltered workshops, recreational and religious, improved and expanded residential centers, and, last but not least, more research into the causes, prevention and possible cures for mental retardation. Each of these needs points up an even greater need for more extensive training for both the professional and nonprofessionals.

Times are changing for the retardate. They now have an increased life expectancy due to the many miracle drugs and with the improved and continued treatment, care and training programs. So now we must plan more and more for the retardates as they grow older.

In years past, when we had more rural living, many of the retardates could live under the sheltered conditions offered on our farms, but now, as we have and are becoming more industrialized and urban, our retardates go wanting for the lack of these protective environs and the lack of preparation and training to fit into the changing world.

The changes make us cognizant of the fact that we have asked for too little and too late, and make us realize the high cost of cheapness. We are filling our State institutions and residential centers way beyond the capacity which they were planned to accommodate, thereby spending more tax dollars.

I would say that it costs between \$300 to \$600 per year to send a child to school for education and training whereas it costs approximately \$1,200 to \$1,500 per year to keep a child in an institution.

From my personal observation in visiting schools and institutions in a dozen or more States, I have become aware of this high cost of cheapness, for I see magnificent buildings erected as institutions for the mentally retarded, beautiful but poorly planned because of the lack of insight into the real needs of these handicapped individuals, when more thought should have been given to "brains instead of bricks."

Adequate but less expensive buildings could have been built which would not have subjected the institutions and the residents there to the short-run savings derived from cheap help, insufficient, inadequate, unqualified, and poorly compensated staffs. This is wasteful, inefficient, and extremely costly in the long run.

Inadequate community facilities necessary for the health, education, and welfare of the mentally retarded cause many of these individuals to become and remain tax consumers rather than taxpayers. Some may have to go to the institutions, but some could live in the community for 10, 15, to 20 years with the proper training and education, and then, when institutionalized, they can become working or contributing members in their new home, thus saving more tax money.

Let's look at this from another angle in thinking of our tax dollars—the family. We sometimes find that, due to the frustration of having a mentally retarded child, the unceasing attention required in

caring for a person who will always remain a child, and the terrific expense involved in seeking and providing help for the retardate, that those responsible or faced with other serious problems, such as broken homes, mental illness, alcoholism—this is one of the compulsions, I guess, the gentleman spoke of yesterday—dope addictions, juvenile delinquency, et cetera. This makes still other burdens on the taxpayer's money whereas, if equal opportunities were offered for our less fortunate children, as are offered for our normal children, whatever normal is supposed to be—and I also have two other children—and if the public were more understanding in accepting our retarded youngsters with their limited abilities, and the parents were helped to adjust to the limited potentials of their child, we could erase some of the social stigma that still causes so much distress in these families.

I have attempted to point out some of the needs for more and better facilities, staffs, and services for the mentally retarded. Federal legislation being considered at this time could go a long way in helping to alleviate this.

I am also speaking in support of H.R. 3465, known as the independent living bill. And I would like to put particular emphasis on titles II and IV. Vocational rehabilitation services should be extended, particularly for our severely retarded and for other severe handicaps.

Is it fair to neglect a person, a fellow human being, because the agency does not feel that he can be vocationally rehabilitated? How can someone be vocationally rehabilitated if he has been habilitated in the first place? Should we not provide the opportunities for these individuals to actually prove their potentials?

This points up the need for continuity between special education services and rehabilitation, especially for the mentally retarded children who will forever remain retarded children.

In closing I would like to say that we as taxpaying parents of retarded children want only for our children what parents of all children want. If it takes more Federal help to enable this special group of children to find their places in society, we urge you to give this your special consideration.

Thank you.

MR. ELLIOTT. Thank you so very much, Mrs. McMeen. You have presented us with a fine, thought-provoking statement.

The subcommittee will take a brief recess.

(A brief recess.)

MR. ELLIOTT. The subcommittee will be in order.

Our next witness is Mrs. Thomas S. Womack, director of the Lions School for Visually Handicapped Children, Inc., Memphis, Tenn.

We are happy to have you, Mrs. Womack. You may proceed in any manner you see fit.

**STATEMENT OF MRS. THOMAS S. WOMACK, DIRECTOR, THE
LIONS SCHOOL FOR VISUALLY HANDICAPPED CHILDREN, INC.,
MEMPHIS, TENN.**

MRS. WOMACK. Thank you, sir. I am glad to be here.

Even though I am here representing the organization stated, I want you to know that I am interested in all blind children.

I do not have a beautifully prepared speech. I am here to state simple facts as I see them and to plead for those facts.

BLINDNESS

As a teacher of preschool blind children and the executive director of a school for blind children, I fully realize the importance of finding these children as soon as possible. At the time when blindness is first diagnosed, it is at this time that the parents need help, learning how to cope with blindness. In so many instances parents will hide their blind children from the public, overprotect them, or neglect them.

Those of us who work with blind children and do counseling with the parents need to find these children to offer our services, but we need help in finding them. We would like very much to have a State law passed in Tennessee which would make mandatory the registering of all people who are found to be blind as soon as the diagnosis has been made. Any physician or optometrist making the diagnosis should be required to report his diagnosis perhaps within 30 days to the proper person, place, or organization. The most logical person, to my way of thinking, would be the director of the division of the blind in the State department of education, or the local board of health and welfare.

By such a law or bill the blind could be given chances to do their best and to become contributing citizens within the community.

Then, may I plead for the mentally retarded children? Another concern, we feel, is for these blind children who are mentally retarded. Where do they go? Why isn't there a school for them instead of institutions for the mental condition where the blindness is not recognized?

So many mentally retarded children are educable and can participate effectively in society with appropriate rehabilitation and education. There are schools provided for the slow learner, the cerebral palsy, deaf, and also the blind. But there is nothing for these children who are multiply handicapped in Tennessee or the southern region. They have the same rights as other children.

The most logical place, it seems to me, would be a unit added in the State schools for the blind where the mentally retarded condition could be studied and helped by the school personnel as well as the Lions. Or perhaps funds, Federal, State, or local, could be set up for the indigent mentally retarded blind child, to be sent to a special school where his dual handicaps would be met and helped, one such school being in Pennsylvania.

This is a most pressing and urgent need in the State of Tennessee. Several of these blind, mentally retarded children, on reaching the age of 7, have been dropped by the Lions School for Visually Handicapped in the city of Memphis. They are all trainable, and most of them are educable if provided with a special school. They could all become contributing citizens, rather than burdens on the taxpayers, in institutions where they are just vegetables receiving only custodial care.

Mr. ELLIOTT. Mr. Quie.

Mr. QUIE. I would like to ask you this question: In Tennessee, is there a checkup given to all children when they enter school to find

out if they have any handicaps of any kind, especially visual handicaps?

Mrs. WOMACK. Yes; there is. Well, I will not say a checkup; no. I do not think that is done. Of course, I am in a private school, you understand, supported by the Lions. But I do think, if there would be any doubt as to the visual handicap, certainly; yes, they would be checked very closely.

Mr. QUIE. Do you not think in many cases this is too late in regard to visually handicapped children?

Mrs. WOMACK. Yes; I do. That is why I think it so important that we find these children. We have found some of the children at the age of 6 and 7, and they were not walking or talking, not because they are blind, but because the parents did not know how to cope with this handicap. They had hidden the children away. They thought there was nothing that could be done for them. They just left them by themselves. Of course, we haven't taught them to walk; we haven't taught them to talk; but we have stimulated them, loved them, and motivated them.

Mr. QUIE. I think there is a great work that has been done by the societies for certain handicapped children which brings better education of the parents.

Mrs. WOMACK. That is true. In the school where I am that is one of the services we offer: counseling with parents. I feel that that is one of the most important jobs in the school. That is why I feel it is so important that we find these children as soon as blindness is diagnosed.

Mr. DANIELS. I note, Mrs. Womack, that your school is incorporated.

Mrs. WOMACK. It is incorporated; yes.

Mr. DANIELS. Are you subsidized or financed by the Lions Club International or by local chapters?

Mrs. WOMACK. Local chapters. Our budget is underwritten by the E. H. Crump memorial football game that we have every fall. And then we have, of course, contributions, memorials, offerings, and gifts.

Mr. DANIELS. How many teachers have you?

Mrs. WOMACK. There are only two teachers.

Mr. DANIELS. Where did they get their training?

Mrs. WOMACK. I, myself, was sent to Syracuse University by the Lions, and to Tufts University in Boston.

Mr. DANIELS. How about the other teacher?

Mrs. WOMACK. She trained under me.

Mr. DANIELS. How many students have you in your school?

Mrs. WOMACK. We have 13, now.

Mr. DANIELS. How long have you been in existence?

Mrs. WOMACK. Five years.

Mr. DANIELS. During that period of time, how many students have you had attending the school?

Mrs. WOMACK. There has never been under 12. The capacity is 15, with 2 teachers.

Mr. DANIELS. And do you conduct a full course in the primary grades from the first to the eighth?

Mrs. WOMACK. No. Ours is just nursery and kindergarten. But we try to get these children socially able and ready to go into public

school, if they are public school material. And one of the schools in Memphis does accept the blind children, and, if they are not, some of them go to the State school for the blind. And, as I just said, we have some who are mentally retarded blind, where they have no school.

Mr. DANIELS. Thank you.

Mr. ELLIOTT. Thank you very much, Mrs. Womack.

Our next witness is Mrs. Marion Thrasher, president of the Alabama Foundation for Hearing and Speech, Birmingham, Ala.

STATEMENT OF MRS. MARION THRASHER, PRESIDENT, ALABAMA FOUNDATION FOR HEARING AND SPEECH, BIRMINGHAM, ALA.

Mrs. THRASHER. I am Mrs. Thrasher, president of the Alabama Foundation for Hearing and Speech, which is a private organization dedicated to promoting activities that will benefit children and adults with speech and hearing problems.

As you are well aware, the availability of trained personnel is the only solution to the problems facing special educational programs. But here in Alabama we have a serious barrier that would prohibit our using trained teachers if they were immediately available.

I am familiar with the system of education under which we operate in Alabama, and I do not believe the Federal Government would take over a matter that is purely a State matter. But I believe the Federal Government can offer help on practical and enlightened systems of special education.

I would say that our most urgent need now, while waiting for people to be trained, is professional guidance in planning and developing special educational programs. Until such time as there is developed, on the State level, a State department of special education, staffed with experienced administrators, trained in the specific needs of each field of special education, the Federal Government, I think, could make available, to communities that requested them, consultants who would study local problems and resources and give advice to interested local groups.

Since 1948 the Junior League of Birmingham has put over \$200,000 into the speech and hearing program that is now established in Birmingham, Ala. Had the medical facts and accurate advice been available within the first 5 years of these efforts, at least one-third of this amount could have been channeled into broadening the scope of the service and making it more effective. As it was, an enormous amount of money and effort was wasted on learning through trial and error that which could otherwise have been saved had there been somewhere to turn for advice. Even now, requests of the Office of Education in Washington, for specific facts and for suggested recommendations regarding the proposed program developments, are not considered on an individual basis, and the general information that is supplied cannot be sufficiently interpreted by us amateurs in order to evaluate in the best interests of those directly concerned.

Throughout the State of Alabama within the past 5 years there have been, to the speaker's knowledge, private groups in Huntsville, Montgomery, Decatur, and Mobile who would have spent time and money in helping to support local education programs had there been somebody to tell them how to get going.

Presently, a group in Pensacola, Fla., is begging me, who am quite inadequate to guide such a project, to come to Pensacola and advise them how to begin a hearing and speech clinic.

Consultants, trained in understanding legislative provisions and experienced in the various problems in initiating special education programs, would lend encouragement and confidence to local lay groups who, in Alabama especially, will have to be relied upon to begin special education programs.

Of course, as you already know, we do need trained personnel to plan, administer, supervise, and teach the special education programs.

This will be a rehash of what you have already heard and what you know, but I would like to say it anyhow.

Direction and coordination of any program before the direct services themselves, of course. But in the poorer States, such as Alabama, well-meaning people have considered it wise to furnish the services and skimp on the trained personnel for the important planning step.

In Jefferson County there is no formal coordination of the 74 existing special education teaching units, and such direction is essential to utilize more efficiently the pitifully insufficient number of special classes.

Based on incidence figures of the U.S. Office of Education, only one-tenth of the children needing special education training are now receiving such help in Jefferson County. Plans were formulated 3 years ago for the five school systems in Jefferson County, which is the county in which Birmingham, the largest city in Alabama, is located.

Plans were formulated to hire jointly a director of special education to furnish the guidance and supervision recognized as necessary. But within these past 3 years no one has been found who was sufficiently trained to assume this position.

Throughout the 12 years of existence in Birmingham of a day school program for deaf children, there have been 3 years in which the entire class of older deaf children has had to be dismissed because it was impossible to locate a trained teacher. Each class dismissed meant that the money and efforts put into the children's previous efforts had been wasted as far as continued oral education was concerned.

In Birmingham, because of a salary differential made possible by the Alabama Foundation for Hearing and Speech, and also because we have not been able to receive State support for but 4 of the 25 speech therapists needed in this area, we have not had unusual difficulty in finding speech therapists. The speech therapy program in the public schools, however, has been operating without a supervisor since the close of the school term in May of 1959, even though the teacher unit and supplemental salary has been available.

Only two answers were received to an advertisement offering the salary in the median range that ran in three trade journals for 6 months, and both of these people received better offers from their old employers.

The Alabama Foundation for Hearing and Speech began offering scholarships in the field of deaf education 2 years ago, and we have found that there are plenty of qualified persons interested in the field. Presentation of the advantages in special education careers and the offer for the education will draw good people right here.

While Alabama is not presently doing its part toward offering job opportunities in deaf education or in speech therapy, there were over 350 deaf classroom teacher vacancies throughout the Nation at the beginning of this school term. These figures do not include provision for a portion of the school-age population that has been generally neglected in special education services—the hard-of-hearing child.

Without supplemental training from a trained speech-and-hearing therapist, this child becomes a costly school failure and also tends to become socially and economically retarded. Educational retardation occurs more than three times as often among hearing handicapped schoolchildren as among those with normal hearing.

They constitute about one-quarter of 1 percent of the school population, or in Jefferson County about 300 children. One hearing therapist in Birmingham public schools is presently serving 15 hard-of-hearing children.

Alabama is so far behind in filling basic educational needs, only 305 special education units for the entire State, that she will hardly allocate funds toward training special education personnel. So we must look to Federal grants for graduate and undergraduate training to fill our needs.

Thank you.

Mr. ELLIOTT. Thank you very much, Mrs. Thrasher.

Are there questions?

Mrs. GREEN. Part of your testimony shows great optimism, that you think there are people that are attracted to this field.

Mrs. THRASHER. We are sure there are. We have applicants right now who want our scholarships for training for this coming year, but we do not have the money for the scholarships. We know of people. We can name them.

Mrs. GREEN. At one point in your testimony you said that there would be individuals and lay groups who would get into this field if they had someone to whom they could go for help and guidance.

Mrs. THRASHER. Yes.

Mrs. GREEN. Are you suggesting that this must come from the Federal Government; that it is not supplied at the State level?

Mrs. THRASHER. Well, it is not supplied presently at the State level, and we feel that that is one reason we need generally trained people in the field. The people who are now at the State level in special education have been people who have learned on the job. They have been well meaning and have exerted themselves to the extent of their abilities, but there is not enough guidance in the State department of education to understand—this is in my opinion, you understand—to understand the general problem of education in Alabama.

There are people who do understand it, but we need to be more infiltrated with understanding throughout the whole department of education before the system can be adapted to what Alabama needs.

We are behind in an interpretation of special education laws and, until we have more trained people who will help the administrators understand the problem, I feel that we will not take any steps toward solving our immediate problems.

Mrs. GREEN. Thank you.

Mr. ELLIOTT. Thank you very much, Mrs. Thrasher. Your testimony will be very helpful to us.

Our next witness is Mr. W. P. McMullan, Jr., president, Mississippi Association for Mental Health, Jackson, Miss. Mr. McMullan?

If Mr. McMullan is not here, our next witness is Dr. T. Earle Johnson, head, Department of Speech, University of Alabama, University, Ala.

It is a real pleasure to have you, Dr. Johnson.

STATEMENT OF DR. T. EARLE JOHNSON, HEAD, DEPARTMENT OF SPEECH, UNIVERSITY OF ALABAMA, UNIVERSITY, ALA.

Dr. JOHNSON. May I say, Mr. Chairman, at the time you were at the university we did not have a speech and hearing clinic. There was very little speech and hearing at all going on in the State of Alabama, speech and hearing training, and it was not until some years later that the clinic was established and we began a training program.

My purpose in appearing before you, however, is to strongly support House Resolution 494, and, if I may say so, its companion resolution in the Senate introduced by the senior Senator from Alabama, Senate Joint Resolution 127.

I should like to urge the immediate consideration of these resolutions and their enactment into law. They are very important, very important pieces of legislation, which take a long step forward in a needed program of training, particularly under title II, the area of competence in which I can speak, relating to the training of speech pathologists and audiologists. There are not enough.

This would not solve all of the problems in terms of special education; it would not solve anything like all of the problems that are existing in the training and work of the handicapped or even in the area of speech and hearing; but it is a tremendous—in my judgment—step forward, so I should like to go on record as urging its early enactment into law.

It provides for training grants and for stipends for individuals in training, working toward the advanced degrees or advanced training in speech pathology and in audiology.

We made a small beginning along this line through the National Defense Education Act. I am not familiar with exactly the way it is administered, because the university is not eligible to apply for such, but in the morning mail I received an announcement from the University of Iowa, for example, announcing national defense graduate fellowships in hearing science, a few that have been allocated to the University of Iowa, for example. There have been others to a few other institutions.

Mr. ELLIOTT. Let me interrupt you a moment, Dr. Johnson.

As I understand it, the University of Alabama or any university would be eligible to receive grants of fellowships in the field of speech if it extended or expanded its department of speech into the graduate level competent to the awarding of a doctor of philosophy degree.

Dr. JOHNSON. That is my understanding.

Mr. ELLIOTT. At the university now, do you give the master's degree in speech?

Dr. JOHNSON. Yes.

Mr. ELLIOTT. So if we could stretch one bit further, we might be able to take advantage here in the southeast?

Dr. JOHNSON. That is a point I would like to make. With your permission, I will skip what I was going to say and come back to that. I do want to speak to that specific point.

In the entire southeast—and by the southeast I will stretch that to include the 14 States represented in Atlanta on Monday and Tuesday—in that entire area there are only three institutions giving advanced degrees, giving a doctoral program in speech pathology and audiology.

Of those three, not a single one, not a single one of them granted a Ph. D. in those areas in the year 1958. I do not have the figures for 1959, but during 1958 there was not a one. So in the entire southeast, there is urgent need, it seems to me, for this program.

In the entire country, there are 135 institutions granted advanced degrees, master's or doctor's. Of course, some 26 gave doctorate degrees, awarded doctorate degrees, in 1958. They gave a total of 123. This is the entire field of speech, including radio, television, drama, public address, and speech and hearing, speech pathology and hearing. So when we come down to that we find there were 35 doctorates awarded in 1958, 22 in speech pathology and 13 in audiology.

Mr. ELLIOTT. Those 35 you would say met what part of the need for that year, Dr. Johnson?

Dr. JOHNSON. Probably one-tenth. A year ago I was looking for an audiologist. I do not know how many were graduated in 1959, but of those I could find only one man getting his doctorate in audiology that was interested in coming south and in coming to the University of Alabama.

I had to compete with four other institutions, including one in the State of Connecticut, in trying to get him here. We compete on a national basis. He came and joined our faculty and is making a very fine contribution.

Most of the ones, however, who did get the degrees and who do get them go back to the institutions from which they are on leave, because it is an inservice training program. At the University of Alabama we serve not just Alabama—as a matter of fact, we serve Alabama in this area to a small extent. We serve the entire southeast of the Nation.

I have seven graduate students in the area of speech pathology and audiology working toward their master's degrees. These seven represent six States, one being from Alabama and two from Iowa.

When they graduate they will not take jobs in Alabama because of the large number of jobs that are available elsewhere at considerably higher salaries.

Mr. ELLIOTT. I do not want to belabor this point, but at the time we passed the National Defense Education Act there were 163 colleges in America granting the doctor's degree. We thought that by the stimulus of the fellowship for the student and the grant to the college of \$2,500 to help get the program underway, that that might result in a great expansion of graduate courses in America, and I think it is having that effect.

Dr. JOHNSON. It is.

Mr. ELLIOTT. But it seems to me we may have hit upon a way whereby graduate work in speech might be expanded here in the

Southeast under this program. I am glad you are thinking in those terms.

Dr. JOHNSON. Those are exactly the terms I am thinking in, sir. I believe that at the University of Alabama, for example, some departments, the department of romance language, to mention one, which has recently announced a doctoral program, I feel that, to a considerable extent, is due to the interest, stimulation, and possibly the scholarships, if they have been awarded, that the university has received in that area under the National Defense Education Act.

You mentioned, I think, a figure of 167 institutions granting doctoral degrees. Of those, only 26 gave doctorates in 1958. There may be a few others, and there have been some recent ones, so at most, probably only 40 institutions, I would estimate, throughout the country, gave a doctor's degree in speech.

That whole area is new. The first course in speech pathology was given in 1950 at the University of Wisconsin. The first doctorate in the area was 1952. So it is new compared with the other endeavors.

If I may quickly summarize, it seems to me that in the area of advanced graduate work in speech, particularly in speech pathology and in audiology, there are three things which might be done in terms of assistance to a university and a department, such as I am affiliated with and have the privilege of being the head of, and that would be first, through institutional training grants and the fellowships, such as are awarded at the present time under other Federal legislation, national defense legislation.

So I would like to endorse that and endorse those features of your particular resolution. A third way in which it might be done would be through the establishment of visiting Federal scholars. We have programs under State Department and under various acts whereby scholars may visit other countries, they go to other areas, and some of these are particularly sought after.

I refer to what are commonly known as the Fulbright scholars, where we pay all or a portion of the expenses of a visiting faculty member from one institution in this country to go abroad.

It seems to me that we need also to adapt that principle to our own country, and in helping us develop in certain areas, particularly in the southeastern part of the country, a program of visiting scholars, where one could come into an institution as a visitor for a year or two, and help and strengthen that particular program.

There is a definite need, I feel, in this particular area. I am thinking of retired professors who might be available for such, and I am thinking of younger and other people who would like to help develop programs in other parts of the country.

So I would suggest that as a third facet and a third way in which support could be given to the establishment of programs, particularly in the area of speech and hearing.

I appreciate very much the opportunity of appearing before you and saying informally these few things which are very meaningful to me. I have been in this work at the University of Alabama since 1928, something that I am giving my life to in my work. I am very much interested in it. I intend to stay in Alabama, promote it and develop it.

I appreciate the opportunity of appearing here. I appreciate your interest and your patience, particularly your patience in sitting here listening to so many of us as we talk about this problem.

Thank you.

Mr. ELLIOTT. Thank you, Dr. Johnson.

Mr. ELLIOTT. Our next witness is Mr. Lloyd M. Dunn, chairman, Education for Exceptional Children, George Peabody College for Teachers, Nashville, Tenn.

STATEMENT OF LLOYD M. DUNN, CHAIRMAN, EDUCATION FOR EXCEPTIONAL CHILDREN, GEORGE PEABODY COLLEGE FOR TEACHERS, NASHVILLE, TENN.

Mr. DUNN. Thank you, Mr. Elliott. We appreciate you and your committee coming to the South to learn firsthand of our needs in special education and rehabilitation.

From the testimony you have already heard here, in New York and in New England, I surmise that there has been evidenced many and similar needs in each of the areas of exceptionality. May I desist from citing facts and figures to support those needs this morning, because we have come to respect the knowledge which you as a committee hold. In fact, I suspect you know these needs even better than we in many of the areas.

Mr. ELLIOTT. May I say to you, Mr. Dunn, that perhaps a little of it has rubbed off on us.

Mr. DUNN. Yes. Permit me to cite three points of view as frames of reference and then discuss briefly recent and pending legislation.

First I should like to reiterate what you heard repeatedly this morning in the strongest plea that the Federal Government give No. 1 priority to the training of personnel. Ordering the morass of recurring evidence that has been presented to you seems possible if you group them in three categories: first, research, personnel, and services. Certainly the aim is to provide better services to all the disabled so they may become better members of society. Both our very way of life and survival depend on us achieving this goal.

While we need research on prevention, on treatment, on amelioration, on training and on education, neither the research nor the services can be conducted in a vacuum. In my judgment the most critical need of all is for the trained personnel I have already mentioned.

Without these highly skilled and learned individuals, worthwhile services and fruitful research will not be possible. Certainly Mrs. Brown's testimony this morning, and Mrs. Green's and others of you on the committee's interest in this point of view supports it.

Turning now to my second plea, for comprehensive legislation rather than piecemeal Federal legislation, we need personnel in each of the 10 areas of exceptionality, and who is to say truthfully in which area there is the greatest need.

We need teachers, we need consultants, we need researchers, we need college instructors, we need programs at the bachelor's, master's, and doctor's levels. In each area and in each level the shortage is acute. We can strive for this Federal legislation one field at a time, and this would involve a great series of bills.

Furthermore, the administrative inefficiency and the legislative problems would seem to me to go on ad infinitum. However, I realize this is the way legislation often comes about. Interest groups in a specific groups mobilize public and legislative support most intensely in their own specialty.

It is difficult to get people excited about broad, comprehensive legislation, even though this type of legislation would serve the best interests of the interest groups in the long haul.

I certainly, however, propose that it would be more statesmanlike, more professional, more economical and more efficient to think in terms of comprehensive bills. Perhaps this inclusive legislation might include provisions for raising the status, responsibilities and opportunities for the various agencies and sections which serve the handicapped and the gifted.

Here, for example, it might be possible to bring closer cooperation and articulation through some sort of Federal coordinating council. This brings me to my third plea. Taking the long view, we would probably be better served by suspending action on Federal legislation at this time until your findings from your long-term special education and rehabilitation study become known.

However, because the need is so great, we would certainly appreciate these findings at least in some form being made available to you as a committee before the end of this 2d session of the 86th Congress. In fact, we would be most delighted if Federal legislation could grow out of the study before the 86th Congress terminates.

From within this framework, I would like now to turn to recent and pending legislation. We are indeed greatly indebted to you, Mr. Elliott, and to your subcommittee, and to the parent committee under the chairmanship of the Honorable Graham Bardon, for Public Law 926.

I believe at the recess you had opportunity to meet two of the fellows presently in that program. I understand in your audience yesterday you had some eight or nine who were from other centers, including Peabody College.

It was certainly an essential first step in getting us out of the doldrums in terms of school programs for the retarded. We need these people and we need many more of them for leadership roles in the South and in the Nation. But Public Law 85-926 has special interest to us at this time on two counts.

First, if comprehensive legislation specifically for training personnel is contemplated, perhaps this might best be accomplished by making minor alterations in 85-926 and amending it to cover all types of special educators.

Second, we can learn much from the operation of Public Law 85-926 even though it has been in operation less than a year if we plan even more broadly and more omnibus legislation. Naturally, difficulties have developed which could not have been envisioned when this bill was written. One problem is the sharp dividing line between section 1 and section 2.

Colleges and universities are restricted to applying directly only for grants to train college instructors. There is also need for the removal of the time and financial ceilings if this law is to be broadened. Researchers cannot be trained under this piece of legislation as it is presently interpreted.

Furthermore, it has not been implemented with respect to the training of teachers of the mentally retarded. I would certainly support Commissioner Derthick and his staff for taking this position. They had a small amount of money. They chose to expend it on leadership and training. That seems to me very wise.

But as you also heard this morning, we also have an acute shortage of the teachers. Other complications have arisen and, thus, if you do contemplate broadening 85-926, I would greatly appreciate the opportunity of testifying before you again on ways of making this law more functional.

In general, more latitude could be built into it, similar to the training programs of OVR and NIH, which are excellent models of simplicity, efficiency, et cetera.

May I turn now to House Resolution 494, and first I would like to say, as you would surmise from my first position, that I am strongly in favor of Federal aid for the training of speech and hearing personnel.

As was recorded in the U.S. Office of Education Bulletin in 1954, teachers of the deaf were more difficult to secure than teachers in any other area of exceptionality, and the number of requests for public school speech correctionists was exceeded only by requests for qualified teachers of the mentally retarded.

I believe this critical shortage has become even more acute in the last 6 or 7 years. However, if it seems expedient to move ahead on this piece of legislation rather than wait for broader and more functional legislation, then may I raise some questions and elaborate on them?

Under title I, first, as the resolution stands now, will only residential schools for the deaf be eligible to apply for grants-in-aid to train teachers of the deaf when more than 25 percent of the teachers of the deaf of this country are employed in the day schools?

Furthermore, in 1953-54 there were 22 colleges and universities in the Nation with full sequences of preparation in this field. Would none of them be eligible to apply directly to train personnel?

Second, does the specified advisory committee have administrative responsibilities? To what degree would it hamper the U.S. Commissioner of Education and his staff in carrying out this measure? Is the membership of the committee as it now stands balanced or would it promote a conflict of interest?

Three, will we be able to train educators to work with the hard of hearing, those children who are less than profoundly deaf under the legislation the way it is presently written?

Under title II, first, does the Office of Vocational Rehabilitation already have authority for training speech and hearing personnel? Does that agency not in fact now support a number of training programs across the country?

Two, are trainees on OVR grants requested to indicate their intent in facilities serving adults? If this is the case, would it be possible to train public school speech correctionists under section 2?

Of the 10,000 speech correctionists presently employed in the United States, more than one-half are working in the public schools. Furthermore, Dr. Wendell Johnson has estimated that probably 90 percent of the speech and hearing therapy provided school-age children is provided from within the public schools.

Turning now to both titles, there are three other questions: Will it be permissible to train personnel at both graduate and undergraduate levels under this legislation?

Two, will it be possible to grant funds to initiate new training programs?

Three, will we be able to train researchers, college instructors and consultants?

Finally, could not a broader piece of legislation serving education, vocational rehabilitation, Children's Bureau, the National Institutes of Health be devised and the authority for it rested in the Secretary's hands of the Department of Health, Education, and Welfare, and thus give us broader coverage, so, as Dr. Johnson said, we would more nearly meet the broad need of turning personnel for speech and hearing positions at all levels of our country?

Mr. ELLIOTT, it has been a privilege to come before you today. I did a good deal of soul searching before presenting this testimony, as you might surmise. It would have been much easier for me to appear before you and point out the general, favorable aspects of 85-926 and the other bill. In fact, I think I could have lived with my friends easier.

But I hope my comments have been useful. They have been intended to serve the interests of all disabled and abled people in the country. First, Federal personnel should be given training; second, comprehensive legislation would be better than piecemeal measures; and third, we should await at least the tentative findings of your study group before taking legislative action.

However, because the needs of special education are so great, we hope that enactments will be possible before the second session terminates.

Mr. ELLIOTT. Thank you very much, Mr. Dunn. Your statement has been very helpful and challenging. I appreciate the efforts you have gone to to point out the ways in which improvements can be made.

At this time for the benefit of the record, I would like you to present the two students who accompanied you.

Mr. DUNN. Yes. We have with us Mr. Haudle, of South Carolina, and Mr. Polk from the fine State of Tennessee.

In case the committee is worried, maybe I should add one other note. I am not a citizen of the United States. I am from Canada, from Saskatchewan, Mrs. Green will surmise.

My family and I have been in this country on immigrant visas since 1950. Thus, we are here by choice.

Mr. ELLIOTT. I hope you will soon have your citizenship certificate. Thank you very much.

Dr. BARNARD. Before adjourning, I would like to request permission that the statement of Dr. John A. Boston, Jr., director of the Austin Community Guidance Center, be made a part of today's record.

Mr. ELLIOTT. Without objection, the statement referred to will be made part of the record.

(The statement referred to follows:)

STATEMENT OF DR. JOHN A. BOSTON, DIRECTOR, AUSTIN COMMUNITY GUIDANCE CENTER

As a physician interested in the problems of mental deficiency, I welcome this opportunity to express professional opinion in regard to the needs of the mentally defective. Some of my opinions are possibly irrelevant to the specific issues under consideration, but are offered because of the opportunity to present them to a distinguished group of citizens. The problems of the mentally defective are important ones for many reasons. Many of the difficulties are unsolvable at the present time and await future scientific achievement. On the other hand, the problems are themselves changing, the approaches to the problems are changing, and many of the old traditional policies can be improved upon. Any Federal aid must be thoughtfully provided or such expenditure of funds will not be effective.

There are four elements which have impact on the problems of the mentally defective.

The first of these is the advent of modern sanitation since the early 20th century. This engineering and bacteriological achievement insures that many of the less biologically sturdy members of the population will live an increased lifespan.

The second factor is the advent of modern antibiotics with the use of sulfa drugs since the 1930's and penicillin and newer antibiotics from 1942 on.

The third significant factor is the use of anticonvulsant drugs, particularly the use of the drug Dilantin since 1935. Anticonvulsant drugs have to some extent eliminated the "epileptic colony" as an institution and, in general, removed the more intelligent and able epileptic patients from such institutions, since modern drugs enable them to function in society. Thus, the ratio of the mentally defective to the epileptic in institutions has been altered so that there are many less epileptics compared to the mentally defective per se.

A fourth and important factor is the interest of scientific disciplines in the problem of mental deficiency, dating largely from the 20th century. It is only in the last 2 decades that psychiatrists, for example, have had a strong clinical interest in the problem of the mentally defective. This is also true of biochemists, psychologists, and many others.

One convenient grouping of mentally defective individuals is the high grade, with intelligence quotients from 50 to 70; the intermediate level, from 25 to 49, approximately; and the low grade, with intelligence quotients below such levels. The problems of each group are different.

Among the low grade defective individuals, there are many with such severe damage to the brain that the individual is incapable of any degree of care of the self and must remain in bed. Prior to some of the developments mentioned above, the lives of such individuals were terminated in the early decades by bacterial pneumonias or other infections. At the present time, institutions such as the Austin State School have roughly a fifth of their population as such cases. Just as the antibiotics and modern sanitation prolong the lives of these helpless individuals, expert medical care in an institution prolongs their lives beyond what it would be if they received intermittent medical care in their own homes. The presence of such individuals in institutions is humanitarian in many respects and relieves the burden for their families. On the other hand, each such patient in an institution excludes one or more other patients who might receive equal or greater benefit from such institutional care. A policy which excluded or decreased the number of such mentally defective individuals, namely, those requiring bed care, from institutions would not be politically popular, but the problem should receive objective consideration. Those low grade defective individuals who do not require bed care in general get custodial benefit only from care in institutions.

Among those in the intermediate level of mental deficiency, there can be a number of satisfactions and pleasures in institutional living. In general, this group do not have many psychiatric (emotional) difficulties, but are in the institution primarily because they cannot be self-supporting and may be a social problem when their lack of judgment leads them into various difficulties. For females of child-bearing age, the risk of pregnancy may be a very important factor in seeking institutional care for such an individual. Efforts to sterilize

such females as a more aggressive way of dealing with this problem have not been pushed and, again, might not be a politically popular procedure. Again, objective evaluation of such policy might be useful.

The high grade defective individual, previously described by the term "moron," who live in institutions are frequently there because of psychiatric and social problems, rather than mental deficiency per se.

There have been a number of scientific papers published, and my own experience is parallel to this, stating that many of these individuals are not in institutions for the mentally defective because of the mental defect in itself. Many such people in this intellectual level, who do not have psychiatric nor social difficulties, are self-supporting and may be substantial citizen-assets. In many institutions for the mentally defective, this group of patients is receiving increasing psychiatric, casework, and psychological care as part of a rehabilitation program. In the central Texas area a private rehabilitation program for young men in this category has had considerable success by training the boys for a 2-year period and then giving them direct help as they leave that institution to go into the community and become self-supporting through their own work efforts.

The psychiatric or social difficulties of such individuals are not always surmountable and many will require permanent institutional care. On the other hand, it is the rare institution, State-supported, which can furnish as much professional help as it would like to offer to such individuals. Certainly, numbers of institutions furnish little or none.

Among those who remain in institutions, sexual problems in their behavior make the institutional adjustment more difficult and may be a significant factor in preventing their rehabilitation outside the institution. Much of the old traditional approach to such high grade defective individuals in the institution is to prevent contact between the sexes because of the risk of pregnancy occurring. It would seem to me that objective consideration should be given to sterilization of some of these individuals and allowing them to marry within and remain within the institution. One might speculate that among such individuals some couples would progress to a self-sufficient existence outside of the institution. The climate of public opinion is probably not ready to endorse such recommendations at the present time, but public values in future years may be different.

Any recommendations contained in the above do not get at the basic causes of mental deficiency. Certainly, the present Federal support of broad research and basic research in these areas is to be commended. On the other hand, scientific breakthroughs in this area may never eliminate all of the causes of mental deficiency and, for the immediate present, eliminate relatively few.

Foster home care outside of the institution is reported to be successfully used by some of the Scandinavian countries for improved psychiatric patients. One would expect that it would be similarly useful for certain high grade defective individuals, particularly if standards can be maintained in the foster home care. Not having had direct experience with such measures, I cannot give specific testimony on this point.

Mr. ELLIOTT. After lunch we will proceed with Mr. C. Robert Graves, of the Florida Federation of the Blind. He will be the first witness.

At this time I have a telegram from Mr. Tom Pettus, from Moulton, Ala., with respect to the testimony yesterday of Mr. Percy Sessions.

Without objection, this telegram will be made part of the record at this point.

(The telegram referred to follows:)

HON. CARL ELLIOTT,

*Chairman, Subcommittee on Special Education and Rehabilitation,
Courthouse, Cullman, Ala.*

My congratulations and my heartfelt appreciation for inviting Percy Sessions to appear before your subcommittee. No one ever became an alcoholic from choice and if it takes 5 to 15 years for one to develop your educational system is lacking and failing the people. Convinced the Alabama Commission on Alcoholism on the prevalence of alcoholism and need for treatment in the dry and

rural area of north Alabama, having courage to undertake this intervention the commission will open an outpatient clinic at Decatur whenever a psychiatrist available. We need more psychiatrists and more of that courage.

TOM PETTUS.

MOULTON, ALA.

Mr. ELLIOTT. I would like to recognize Dr. J. Howe Hadley, former Tuscaloosa city school superintendent. We are happy to have him with us.

I understand Dr. Hadley was formerly with the Louisville, Ky., school system, and is now professor of education at the University of Alabama.

The committee will stand in recess until 1:45.

(Whereupon, at 12:30 p.m., the subcommittee recessed, to reconvene at 1:45 p.m. the same day.)

AFTER RECESS

(The subcommittee reconvened at 1:45 p.m., Hon. Carl Elliott (chairman of the subcommittee) presiding.)

Mr. ELLIOTT. The subcommittee will come to order, please.

We are ready to begin again with the witnesses that we had left from this morning.

Our first witness is Dr. William P. Dorne, chairman, special education committee, Auburn University, Auburn, Ala.

We are happy to have you, Dr. Dorne. You may proceed as you desire, subject, of course, to our limitation of about 10 minutes.

STATEMENT OF DR. WILLIAM P. DORNE, CHAIRMAN, SPECIAL EDUCATION COMMITTEE, AUBURN UNIVERSITY, AUBURN, ALA.

Mr. DORNE. Mr. Chairman, members of the committee, it is an honor, and I come before you with some humility before this Subcommittee on Special Education.

I would like to appear as a private citizen and as a member of the professions of speech and hearing disorders and special education.

As a citizen, I am extremely interested in the welfare of children. As a member of the teacher-training program, I am interested in, if I may use the phrase, turning out the best possible product that I am capable of doing.

As we all know, there are tremendous educational problems facing the Nation today. This is true in the South and it is true in Alabama. Many of these problems are unique to Alabama, but there are many general problems as well. These problems have a way of filtering down to special education and to the areas of speech and hearing.

Dr. Dunn this morning refused to give any statistics or incidence figures. I would like to do the same thing. I would like to leave them out.

That 2-day study commission in Atlanta undoubtedly has supplied you with some excellent reports, and your own fact-finding agencies probably will do the same. But I wonder if you have been exposed to the problems of the parents, the teachers, and the children.

If I may, I would like to read a sentence or two from three letters that crossed my desk in one week, in January, from three rather different sources. The first one:

I am interested in learning the name and address of the association working with retarded children in Auburn.

There is no association in Auburn working with retarded children. The second one:

I am writing asking for information about schools for mentally retarded children.

By and large, there are no schools for mentally retarded children: classes in an occasional private school, but very few schools.

The third one:

Recently the Valley Association for Retarded Children has been organized in Chambers County. The group is very enthusiastic and has started a day center for trainable, retarded children. Now, of course, they have to find a teacher.

This last sentence, "Now, of course, they have to find a teacher," is the thing that really disturbs me. I doubt that there is one available teacher of the trainable child in Alabama today.

This is not to say that Alabama has not made progress. Five years ago there were a handful of special classes in the State of Alabama. Today there are over 300, as Mrs. Brown mentioned. This does not mean that we have done all this and we have nothing else to do. Many of these classes are not set up on the proper foundations, and we need to re-do much of what we have done. Our teachers need much more and better training than they have been able to get.

Last night I taught a class in south Alabama. Two things happened in that class, things that we are not taking care of in special education in Alabama today. One English teacher said, "What do I do with the gifted child?"

This was a good question. I don't think I had the final answer for it.

A principal of a good school in this community, treating some 1,000 children from Daleville and Fort Rucker, said he would like to have a speech therapist for next fall, and, oddly enough, I could give him one. I happened to have five available, and this is a little unusual. But we have no units and we have no money.

Some of our participants in the last day or so have mentioned preschool classes. This is practically unheard of in Alabama. A child of 3 years of age with cerebral palsy or being blind or deaf going to school—we are coming to it. It will be in our lifetime.

These are just a few problems that we have facing us. Some people would have you believe that these problems are the sole responsibility of the Federal Government. I disagree with this. I think a large proportion of our problems should be met by the local and State governments. Yet I think in some instances the assistance of our Federal Government has been needed for some time and is needed today.

I think the introduction of House Joint Resolution 494 is a step in the right direction. There may be many steps to follow; but this is a step, a positive step, forward. I am not overly concerned about Federal encroachment.

If, as we talked earlier with the Representative from Minnesota, you will set up minimum standards, I think we will abide by them.

In closing, I would like to say that the total committee is to be congratulated. I trust that this bill will be enacted very shortly.

Mr. ELLIOTT. Thank you very much, Dr. Dorne.

I recognize the gentleman from Minnesota, Mr. Quie.

Mr. QUIE. I have just one question. You mentioned schools for retarded children. Do you think there should be residential schools for retarded children?

Dr. DORNE. I would say not for what we usually consider the truly mentally retarded child, the child that is educable. I think this child often is and should be educated in the public schools. I think the trainable child is another problem, another case, and I think maybe a day school or even a residential school will be one answer to the solution of this problem.

Mr. QUIE. You were referring to the trainable child when you were talking about schools for the retarded child?

Dr. DORNE. I am not sure what the parents meant; whether it was a trainable child or an educable child.

Mrs. GREEN. Is not the trend across the country getting away more from the institution for the mentally retarded and the feeling that, if this youngster can be kept closer to his home and his own community and the love and security that that would give him, it would be better for him?

Dr. DORNE. Yes, Mrs. Green; this is very true.

Thirty-two States, I believe is the figure, have now made some provision for the trainable child in their public schools. Many school administrators are fighting this because they are a little leery, and they should be leery in a sense. But this letter concerning the establishment of a day center, I have talked to the school people of that community, hoping to get them to go out on their own and start a trainable class. It would be the first one in Alabama in the public schools. But they are not willing to take the bait yet.

But you are right; we are getting away from institutionalization of the trainable child and trying to put him in a residential school, a day school, or even a sheltered workshop where he can perform at his level and be at least partially self-sufficient. He may never be completely self-sufficient.

Mrs. GREEN. Do you see any hope of meeting these problems until the American people are willing to give higher priority to education in general and higher priority to special problems in education and are willing to pay the necessary money to attract the qualified personnel.

Dr. DORNE. No; I think you are right. I don't see much hope for it until they are made aware of it and are willing to pay the price. I think, in relation to the matter of Federal aid and State aid, I believe our Governor is in New York today, trying to get bonds or a loan for \$100 million for school construction. This type of money doesn't come easily to a State like Alabama.

I think we are trying, but I think there is more that can be done by a State and local government, and I also think the Federal Government must help. But you are right: I think that the matter of public education is of tremendous importance.

Mr. ELLIOTT. Thank you very much, Dr. Dorne.

Our next witness is Mr. A. D. Croft, president, Association of the Blind of South Carolina.

Mr. Croft is not here.

Our next witness is Clay S. Sheffield, a director of the Guidance Department, Birmingham Public Schools, Birmingham, Ala.

Mr. SHEFFIELD. Thank you, Mr. Chairman.

Mr. ELLIOTT. We are happy to have you, Mr. Sheffield. You may proceed in any manner, subject to our limitation of about 10 minutes.

STATEMENT OF CLAY S. SHEFFIELD, DIRECTOR, GUIDANCE DEPARTMENT, BIRMINGHAM PUBLIC SCHOOLS, BIRMINGHAM, ALA.

Mr. SHEFFIELD. Thank you, Mr. Chairman and members of the committee.

I have prepared some suggestions or ideas of ways that I feel that this problem of special education might be met. However, in view of the fact that all of these have been covered by previous witnesses, I will depart from the written statement and mention a few as a matter of emphasis.

Mr. ELLIOTT. Mr. Sheffield, let me say that, following your oral presentation, without objection, we will make your written statement a part of our record. Then the record, when it is written up, will carry your oral statement plus the written record, both.

Mr. SHEFFIELD. Thank you.

As has been stated here previously by practically every one of the witnesses, it is my feeling that the greatest need in this area is personnel, trained personnel, not only teachers but administrators, school psychologists, social workers, and everyone dealing in this entire broad area.

I would like for emphasis to say "Amen" to what Dr. Dunn said this morning in talking about combining the areas of special education, rather than treating them as separate little islands.

We talk about people who have special handicaps or special disabilities, considering them as a group rather than individually, because most of them have multiple disabilities rather than one.

Mr. ELLIOTT. You are, of course, talking, Mr. Sheffield, about the ideal, and with which I agree, but the legislative mind is something to ponder. When it gets ready to legislate in a particular field you can get legislation, and if it is not, you cannot. So that accounts, I think, for the piecemeal approach.

Two years ago we did, I think, a rather beautiful piece of legislation for the mentally retarded, and we were able to do it at that time, and under somewhat unusual circumstances. But had there been attached to that bill several other categories we could not have passed it.

So, really and truly, what you say is the ideal, and I subscribe to it as an ideal. But I do not know whether we will ever be able to achieve the type of omnibus approach about which you are speaking or not. I just say that for whatever it may be worth to you.

Mr. SHEFFIELD. Perhaps there could be some provision made in the legislation for these individualized disabilities so that there could be some coordination.

The thing that disturbs me is that we seldom find a mentally retarded child that does not have some of the other disabilities that go along with it. If we take each one and quote them percentagewise, we find that we have about 60 percent of the population which has disabilities, which, of course, is not a true picture. That is the kind of thing I had in mind.

Another thing is—I have not heard it mentioned here, but I think it is very important—that we need special physical facilities for dealing with these people. I am not so sure that that may deserve special thought and consideration, because you get a good teacher, well-trained teacher, identify the people who need the help, and then have no room except one that is not being used but which is keeping the janitor supplies in the schools, and you empty that out and drag the children in there.

That is a critical problem. Buildings are critical in the whole area of education. Again, maybe this is a State problem, but I think maybe Federal recognition of it might help overcome this.

Mr. ELLIOTT. When you start to legislate in this field, again, and I have been through it now for 12 years, all too often the people who argue that the Federal Government should not contribute anything to these facilities, when the legislature meets they go down and argue that the legislature should not do it, and then when the city council meets they say that the city council cannot do it. So you get sort of a ring-around-the-rosy effect.

I think we apply sometimes to these educational problems a much higher degree of caution than we do in any other field. Nobody in my district has said to me that the Federal Government should not spend \$9 for each \$1 that the State spends to build these beautiful highways, all of which I voted for and which I subscribe to, but nobody feels very much hesitancy about that, and we are willing to tax and retax ourselves in order to do that. But when we get into the field that you are talking about, one in which you and I know that somebody has to answer to the full responsibility, then we invent, oftentimes, I think, as fictions of our own minds, all of these excuses that prevent us from making the progress that a free civilization has to make if it continues to be free and if it continues to lead the world. Of course, that is my testimony, and not yours, but that is pretty much the way I see it.

I agree with you that if we had the facilities, if we had some way to get the facilities, we could have these special education schools and these workshops to train the handicapped all around.

We have a little facility in my hometown because a lady over there, Mrs. R. L. Cheatham, was gracious enough to give us the rent of the building for 5 years. Had that not happened, we would perhaps not have the facility there today.

Mr. SHEFFIELD. I am glad you agree with us on that, because that is one of the big problems.

As I say, these facilities generally are facilities that are not really needed for anything. But we have nothing in that area. Of course, not only a room, but other equipment is needed for this special type of program.

I would like to mention one other thing, and this perhaps can be helped by legislation or maybe it can be done through liberalizing of

directives. That is this business of the coordination of the various agencies that deal with the child.

I don't know if this legislation is needed here or not. But I think if we could all begin to work together, and I think some legislation might be needed to promote this, but we are all going to be eventually working with the same person if they are a handicapped person, so why not start when we can all combine our efforts. I do not know how that should be written into legislation, but it is a thought that I have had.

In working with some of our people, we do try, but there are certain lines beyond which we cannot go. Vocational education, for example, in my understanding, cannot use their coordinators in D.O. & D.E. for working with certain of these retarded people, for example, unless the retarded people are capable of becoming trained for a job needing 1,500 hours—I believe that is correct—of actual training, in knowing a trade. They do not need to learn a trade, but they do need job adjustment and supervision.

I think the vocational coordinators could be a big help in helping job adjustment. But they do not need the training to learn to wash the car, if that is the kind of a thing that they can do as far as trade training.

One other point is I would like to say what I think about the residential homes or schools or facilities. I have a great feeling that we need more residential facilities than we now have. Not only do I think that we need them for people who are not going to be able to be self-supporting and self-directing in a free society, but also for those who need it temporarily. Some will need it permanently, but some will need it temporarily.

I think here, because of the type of home situation they have, or lack of home supervision they have, we find that sometimes we can bat our brains against a stone wall trying to help a youngster, and send him to an environment at night where they undo everything we did during the day with them.

So it would be a great help to have a facility, properly staffed, where we could use those youngsters while we are working with them, and eventually they would be on their own. That would go beyond the mentally retarded. It might go into the emotionally disturbed. I am not thinking of the mentally ill here, but some of the others, the predelinquent type of youngster.

I had an idea that perhaps the CCC-camp idea, a camp work situation for 14- and 15-year-olds might be a good one.

Mr. Chairman, thank you for your indulgence. I am glad to have an opportunity to appear before you.

Mr. ELLIOTT. Thank you very much for your testimony.

(Prepared statement of Mr. Sheffield follows:)

STATEMENT BY CLAY S. SHEFFIELD, DIRECTOR, GUIDANCE DEPARTMENT, BIRMINGHAM PUBLIC SCHOOLS, BIRMINGHAM, ALA.

NEEDS AND RECOMMENDATIONS FOR MEETING THE NEEDS IN AREAS OF SPECIAL SERVICES AND SPECIAL EDUCATION

I. One of the greatest needs, as I see them, in the area of special education is more trained professional personnel. This would include not only teachers, but school psychologists, school counselors, and school social workers.

I would recommend that this program of training personnel receive the same priority as the training of guidance workers and mathematics and science teachers receive in the National Defense Act. I would recommend further that fellowships and cost-of-living grants for short-term and summer workshops be set up for training in these areas similar to those set up to train guidance persons, mathematics and science teachers. I would recommend that a limited number of fellowships and cost-of-living grants be made to persons of demonstrated ability and interest in these fields, where not only school expenses but allowances for dependents and subsistence for the individual be provided for training toward doctoral programs in order that we might provide a high-type leadership to further develop the programs in special education. I would recommend that the program for training school guidance personnel be broadened and extended so that children, and the parents of children, in the elementary grades would receive help at an early age, where our experience has shown that it is most effective.

II. Provision needs to be made for the construction of suitable facilities for meeting the needs of handicapped children which would include rooms in schools designed specifically for the handicapped and also special equipment needed for working with the area of the specific handicap.

This could probably be provided on some system of matching funds that would encourage State and local boards of education to include this type of building and equipment programing in all new school plants.

III. There is a need for better coordination of the services of special education, vocational education, and vocational rehabilitation in working with the handicapped in all categories. This is especially true as it relates to the high-school-aged child.

In this connection, it is possible that some liberalization of legislation with regard to specific requirements in vocational education might be made to allow the vocational education people to work with those individuals whose capabilities are limited to the unskilled and service fields. Vocational education and rehabilitation personnel could serve on the team with special education personnel in job replacement and job adjustment training and supervision.

IV. There is a need for some provision to remove some young people from their home environment and to provide supervision while efforts are being made to assist them in making a satisfactory adjustment to society. These people would not be individuals who would be identified as delinquent. They are, however, potential delinquents. Frequently these young people constitute a major problem to the public schools and the community because of an attitude of antagonism toward compulsory school attendance. They are frequently young people who are too young for the competitive labor market.

I would recommend that some work-camp facilities, along the lines of the CCC camps, be set up where these young people would have specific job requirements, where recreational facilities and education programs would be provided for those who showed an interest. These camps would need to be adequately staffed with people trained in working with young people.

Mr. ELLIOTT. Our next witness is Dr. Mode L. Stone, dean, School of Education, Florida State University, Tallahassee, Fla.

STATEMENT OF ELLEN THIEL, COORDINATOR OF SPECIAL EDUCATION, FLORIDA STATE UNIVERSITY, TALLAHASSEE, FLA.

Mrs. THIEL. I am Ellen Thiel, coordinator of special education at Florida State University. The invitation to testify was originally sent to me. I was unable to come, and Dr. Stone was to come in my place. He called me last night and said he could not come, so I came.

Mr. ELLIOTT. Well, we are happy to have you, Mrs. Thiel. Would you state your position for the record, Mrs. Thiel?

Mrs. THIEL. I am in charge of the training of teachers in various areas of exceptionality in the College of Education at Florida State University at Tallahassee.

Mr. ELLIOTT. We are very happy to have you with us today, Mrs. Thiel. You may proceed with your testimony.

Mrs. THIEL. Thank you, sir. Your invitation invited us to talk on two points; one relative to pressing needs in the South, both in relation to special education and vocational rehabilitation. I would necessarily limit myself to special education.

Secondly, any specific suggestions we might have in terms of how Federal aid could help us. I think we need perhaps to take a view of the problem that is far more common in the South, apparently, than any of the testimony given at the New York hearing or such of the Connecticut hearing as I have reviewed thus far indicates. It will be the kind of thing I am sure you will encounter as you move out to the Mountain States.

We have in Florida, for instance, some 900,000 school-age children. You probably know that the political organization in Florida results in 67 counties which also form the basis of our public school system. Nine of these counties represent 20 percent of the area of Florida, but they furnish 64 percent of the school enrollments of 900,000 children. This means there is an average of 54 children per square mile among this group of counties, although the counties themselves are scattered to various points around the State.

Of the remaining 58 counties which do average an area of 750 square miles, we run an average of 7 pupils per square mile. This has tremendous implications to needs in special education.

If, as a rule-of-thumb, you automatically said 10 percent of school-age children deviate sufficiently in terms of some functional difference so that we must provide some unique educational plan in order for them to achieve, it means that 10 percent of 7 pupils per square mile cannot be handled in any way similar to how you would handle 10 percent of 54 children per square mile.

Our teacher-training programs that are tops in the Nation now grew up in metropolitan areas where they had hundreds of children with similar kinds of problems to deal with.

I think one of the most urgent needs we have in the South, and I know this is true in the Mountain States where I worked for 4 years at the University of Utah, is the need to improve not only the quantity of service but the quality of service to youngsters in nonmetropolitan areas. The need to break through into new frontiers, new ways of organizing our special education services, new forms of service, are necessary.

In Utah, for instance, we are averaging only six children per square mile throughout the State. So here you have a different problem.

It also challenges us to a point which the previous gentleman referred to, the need for much fuller communication and cooperation in all the seven forms of special services that are concerned with exceptional children, not just special education teachers as such. This is another demand that we are feeling a tremendous need for.

We can have an excellent beginning in the South, and as it happens it relates to teacher education, the idea of regional planning, having surveyed the South to find what were the needs, and then recognizing that not every institution would be warranted in setting up a program, but, rather, to determine which would lend itself most easily to move into this and not drain off energies, the few personnel there were, and so forth, to concentrate in these programs.

We need a great deal more of this kind of thing, not only in relation to the teacher education aspect of it, but all other aspects, not only at the regional but at the State level and within the State within the county, within the community.

Our State universities should be looking at each other in terms of "What do we have that can supplement what you have?" How can we make the most of what we have, because there are too few?

In this connection, I would like to move to the very specific kind of needs that we are feeling at the Florida State University, not necessarily because they are unique, except that our teaching trainer program is perhaps presently unique in the Nation.

We have broken down the pigeonholes. We are not training teachers in any specific area of exceptionality. We are training teachers for exceptional children because that is the way we find them in the nonmetropolitan areas. We do not find clear-cut classes with only children with intellectual handicaps and so forth. So we have moved to a comprehensive training program, starting it 18 months ago. Give us 3 more years and we will brag about it.

Now we are just whispering. But in this connection we are saying the same thing to everyone who will listen to us. We need personnel. We can be specific in terms of how we need them, but I would rather move onto another point.

We need demonstration centers, actual facilities. Not only are they needed, as the previous gentleman indicated, but they are essential in our training centers where we can at least show and demonstrate what could be possible out in the other counties, and so forth.

We need material production of various sorts to help us in teacher training. This is not disregarding the need actually out in the special education situations themselves. Of course we need scholarships and fellowships. The excellent start that was made with Public Law 85-926 is a heralded beginning.

On the other hand, we must not overlook the fact that graduate students don't just spring up from seed. They come up out of undergraduate programs, and we need help with our undergraduate programs because the cost of training a special education teacher at the undergraduate level is greater than the cost, let's say, of training a straight elementary teacher.

We had 20 undergraduate majors a year ago at Florida State in the field of special education. We have just put them through the last 2 years of what eventually will be a 4-year program, and we are running cost data now on the excess cost of training, at undergraduate level, a teacher in the field of exceptional children.

Of course, there is the constant need for experimentation and research. These are not new things. You have been listening to them now at three different points in the country, plus all the correspondence I am sure you are encountering.

I was not able to be here this morning. I recognized from some earlier remarks this afternoon that Dr. Dunn apparently took a stand; you refer to it as ideal and I, too, shall be guilty of being an idealist, but a persistent one.

I think to meet the last point on which you invited me to speak, specific suggestions on which I can help you, that you as a committee,

and you, particularly, Mr. Elliott, have the know-how. You have already done the job. You have made your own pattern for how you can help us best.

As you reviewed the testimony, you recognize that each of us more or less represents a particular area of exceptionality, and this is what we are fighting for. But as you read across the lines, we are not disagreeing with each other, we are not saying "We don't need this, you just need mine," but we are just all bombarding you with our needs.

I recognize and appreciate what you say in terms of the legislative mind, but you have already done this job once. Do it for us again. Think through the things we have asked you for and others will be asking you for and go down the 10 acts of your NDEA. They are all there.

We want fellowships as in your title IV: we want differential diagnosis, which is a carrythrough and beyond of your guidance counseling services in your title V. We want research. We want informational services; we want improvement in administrative patterns and data processing and so forth.

You have the pattern. Write it up this time for exceptional children. Give us a national defense act in special education.

Your NDEA bill has been referred to as the Canaveral of education. Give us a bill of rights for exceptional children.

Mr. ELLIOTT. Thank you very much.

Our next witness is Dr. Warren B. Weil, physician, of Birmingham, Ala. Is Dr. Weil here?

If he is not here, we will pass on to Mrs. Venoa Daniels, of the Alabama Nursing Association.

You may proceed, subject to a terribly arbitrary rule of 10 minutes.

STATEMENT OF VENOA DANIELS, COMMITTEE MEMBER, LEGISLATIVE COMMITTEE, ALABAMA STATE NURSES' ASSOCIATION

Mrs. DANIELS. Thank you.

Mr. Chairman and members of this committee, I am a member of the legislative committee of the Nursing Association of Alabama. I am not the chairman. Therefore, I have a prepared statement. If I may, I would like to read this statement.

Mr. ELLIOTT. You may.

Mrs. DANIELS. Although the nurses' association is not directly involved with the proposed legislative bills, House Joint Resolution 494 and H.R. 3465, and we are not speaking regarding testimony for or against these measures, we would like to be heard regarding our support of any proposed legislation in the fields of special education and rehabilitation. Nurses feel they have an important stake in these areas.

Because of our interest in the groups that can be helped and because of the numbers of special nursing problems which might result in the care of the handicapped individual, nurses in this State, as well as nurses in other States, are interested in helping to alleviate these problems. We recognize that many disabled persons are in need of

nursing care and, as their need for nursing care becomes less, other needs may become greater.

We would like to go on record as being willing to support legislation that will help the handicapped individual sufficiently to allow him to return to a more normal pattern of living.

We would also like to place emphasis on the educational aspects; more trained personnel—qualified teachers, therapists, and so forth. Wherever the handicapped people are, provision for the best diagnostic evaluation of the handicapped, full use of present facilities, with new facilities added where needed—avoid duplicating facilities—so the handicapped can be educated to do something.

As an individual citizen, myself, I have looked at the outline, and if I may make a statement on my own, I certainly would like to say: You have spelled out many of the illnesses and diseases that affect the human being, for instance tuberculosis. All of these are greatly important, you have something here where my statement could come under "others and rehabilitations," but I still would like to say, as an example, cardiac patients, because heart attacks have no respect for age today. That individual needs help at the bedside today in regards to his employment back into society.

I thank you for the time before this committee today in behalf of my association and myself.

Mr. ELLIOTT. Thank you very much.

At this time the committee will take a 5-minute recess.

(Brief recess.)

Mr. ELLIOTT. The subcommittee will be in order.

I am happy to note that in our midst is Mr. Plunkett, the resident chancellor of the county. We are happy to have him with us this afternoon.

Our next witness is Marvin P. Mantel, director, the Success Shop, Montgomery, Ala.

STATEMENT OF MARVIN P. MANTEL, DIRECTOR, THE SUCCESS SHOP, MONTGOMERY, ALA.

Mr. MANTEL. Mr. Chairman and members of the committee, I will implement that title by saying that I am the director of the Success Shop, which is the vocational rehabilitation workshop for the handicapped.

It is a privilege to meet with members of the Subcommittee on Special Education to give support to the H.R. 3465 sponsored by Congressman Carl Elliott. I am familiar with the general provisions of the bill and should like to comment on the part dealing with workshops and rehabilitation facilities.

We approve the provision in the bill to provide for Federal grants to nonprofit agencies or organizations to pay part of the cost of building workshops and rehabilitation facilities. It should continue to provide for expansion and improvement of workshops and facilities now in operation.

It should further provide for the equipping of buildings and also a program of diagnosis.

We also would like to see grants to State agencies administering State vocational rehabilitation programs, to pay part of the cost of

rehabilitation services to severely handicapped individuals who can be helped to achieve reasonable self-sufficiency in meeting the normal demands of daily living.

The most frequently used services in workshops are:

- (1) vocational diagnosis and evaluation;
- (2) vocational and personal adjustment training;
- (3) vocational training; and
- (4) continuing employment.

Workshop personnel are ready to admit that the workshop staff must be adequate in number, and will demand professional staffing either as an integral part of the workshop or on a coordinated community plan.

We need Federal participation in initial staffing beyond the present 1-year provision of Public Law 565.

One of the greatest services workshops can render is evaluation and diagnosis. This program is now being carried out in a small scale. We know there is a great need for expansion of this program. Although much specialized diagnosis and evaluation, together with a thorough testing program, may precede admission to the workshop, continued diagnosis and evaluation are necessitated. Breakdowns and failures are not always vocational in origin. Evaluation should continue under the work situation.

The effect of work upon physical, social, and emotional conditions, and these conditions upon work, need to be known and evaluated. Only by a long and sometimes painstaking program of evaluation can we determine whether sheltered workshop training can rehabilitate mentally retarded young adults or other individuals with great limitations whose employment had previously been considered impossible.

It is our opinion that we must move more vigorously in the direction of reducing our expenditures for public assistance by preventing dependency. We believe that democratic principles are, in essence, humanitarian; therefore, as understanding and vision grow, the concept of the greatest good for the greatest number expands without losing the focus on the rights and privileges of the individual.

The greatly increased activity in the field of legislation is one important evidence of the respect of human life and the dignity of the individual which is basic to the American way of life.

We believe that community nonprofit organizations can best carry out a comprehensive evaluation program through the establishment of well-equipped and well-staffed workshops. We must have adequate and suitable buildings, suitable staffing and equipment. This staffing should include instruction in remedial work for those whose education is so limited, that it will require additional general education for them to learn the basic skills in accordance with vocational aptitudes.

Thank you.

Mr. ELLIOTT. Thank you very much, Mr. Mantel.

Are you related to B. G. Mantel?

Mr. MANTEL. I happen to be a brother.

Mr. ELLIOTT. I am happy to meet you and happy to have your testimony.

Mr. MANTEL. Thank you, sir. I enjoyed being with you.

Mr. ELLIOTT. Our next witness is Judge Bernard A. Reynolds, the probate judge of Dallas County, Selma, Ala.

May I say, Judge Reynolds, we are happy to have you. You may proceed in any manner that you desire to give us your testimony.

STATEMENT OF HON. B. A. REYNOLDS, JUDGE OF PROBATE, DALLAS COUNTY, ALA.

Mr. REYNOLDS. Thank you, Congressman.

Congressman Elliott, members of the committee: It is certainly a pleasure to be here, and I appreciate the privilege of being given this chance to testify.

I have read the bill and the resolution concerning vocational rehabilitation and special education, and I would like to support this program as a whole. One part I would particularly like to discuss is on the bill dealing with expanded rehabilitation services, including workshops and facilities.

Mr. ELLIOTT. Judge Reynolds, let me ask you: Alabama has not scratched the surface in building workshops for our handicapped people that we are trying to train through special educational procedures. What is a practical approach to get that done?

Should we have some Federal aid for that type of a building program or how should we approach that?

I ask you that as one of Alabama's leading citizens and as the chief official of one of our leading counties. If you do not want to answer now, I want you to think about it and write to me about it, giving me your thoughts about it.

It seems to me, and you and I do not think far differently about these matters, that there are fields, such as maybe the one we are talking about, in which the Federal Government can act as a sort of catalyst—if you speak of it in chemical terms—to help get one of these programs underway. I wish, and I have made this statement many, many times, that it were possible that we in Alabama could do every one of these things for ourselves and still have plenty of money left over to do the other things that we need to do. But we are in a constant strain, so to speak, to get the money with which to do many of these wonderful, worthwhile things, that ought to be done. You think about that sometime and let me know how you feel about it.

Mr. REYNOLDS. Thank you, sir.

I would like to write you in regard to that, Congressman. I think it is nice that you have asked me to do that. I certainly will give it thought and let you hear from me.

We do need some Federal help. I think it should be planned.

To digress just a moment, we in Selma, Dallas County, have built a workshop. It was done through the Civitan Club and local help. We have a facility there that I think is second to one, only in size, and one that we are very proud of. We would be proud to have you and your committee come and visit us and see what we have been able to do with some help through rehabilitation. The rehabilitation program has been the one to spur it on.

It would like to say that the Civitan Club and the Lions Club of Dallas County have done a wonderful job.

Mr. Elliott. How many do you accommodate through this program in Dallas County?

Mr. REYNOLDS. We have a regular training program where we are able, at the present time, to train around 50 constantly under a train-

ing program in this workshop, in bookbinding, upholstery, woodwork, printing, and through the fact that we have some wonderful people on social security there, who are really well-trained men, we can afford the best as our teachers.

Mr. ELLIOTT. You are certainly to be commended on that accomplishment in Selma.

Mr. REYNOLDS. Don't give me credit for it, please, sir. It has been done without me.

Mr. ELLIOTT. I have an idea that you have been helping it along as the years have gone by.

Mr. REYNOLDS. Well, I had a little part that I am very proud of. I think it is wonderful that I was asked to help on it.

Mr. ELLIOTT. Thank you, sir.

Mr. REYNOLDS. I have been closely associated with, and in fact a part of, the total rehabilitation effort in my county by virtue of my interest and as chairman of the probate judge's committee on employing the physically handicapped. I have seen excellent community participation and remarkable rehabilitation results.

I have also been aware of severely handicapped individuals who could not be rehabilitated due to lack of funds and facilities.

It is my belief that communities should be allowed to raise money which would be matched by Federal funds, subject to approval of the State rehabilitation agency, not only for construction of facilities and workshops, but for their expansion and improvement. This should include equipment and staffing on a continuing basis, with Federal funds being matched locally.

I believe that facilities should include halfway houses for the mentally ill, mentally retarded, and that special education classes for upper-age children should be established in approved rehabilitation facilities and workshops, with staffing provided by Federal funds on a continuing basis as above.

I have been advised that surplus equipment has been denied rehabilitation facilities and workshops. It seems to me that no group could better utilize this equipment, since the prime purpose of these facilities and workshops is to evaluate, train, and employ disabled people.

I recommend that this provision be added as an amendment to the Rehabilitation Act of 1959.

There are other factors I could mention, such as the need for additional staffing of trained personnel in rehabilitation and related professions, such as psychiatric social workers, therapists, et cetera. These points illustrate the need for an expanded program in the fields of rehabilitation and special education and I submit them for your consideration.

Thank you for permitting me this opportunity.

Mr. ELLIOTT. Thank you very much, Judge Reynolds. We are very happy to have had you.

I recall, myself, your interest in this field is of long standing and that you served on the Alabama Commission for Mental Health, did you not?

Mr. REYNOLDS. I still do; yes, sir.

Mr. ELLIOTT. I knew at one time you served on that commission.

I want to congratulate you on the program that you are getting under way in Alabama for our mental health program. I think it is a great advance over what we have had.

Mr. REYNOLDS. Thank you, sir.

I certainly hope we will be able to put over amendment No. 1 on our constitutional amendments on February 16 in regard to the \$3 million bill, which will not increase our taxes.

Mr. ELLIOTT. I hope so, too.

Our next witness is Miss Irene Perkins, of the American Occupational Therapy Association, Dublin, Ga.

If Miss Perkins is not here, then our next witness is Jasper Harvey, coordinator of education for exceptional children, University of Alabama.

We are happy to have you, Mr. Harvey. You may proceed as you choose, subject to our usual time limit.

STATEMENT OF JASPER HARVEY, COORDINATOR OF EDUCATION FOR EXCEPTIONAL CHILDREN, UNIVERSITY OF ALABAMA

Mr. HARVEY. Thank you, Congressman. It is a pleasure to be here with you and to have an opportunity to testify.

I feel that since we have gotten into the area of exceptional children from a teacher-training level, a little late in Alabama, that possibly in outlining some of our urgent needs in the teacher training level I can speak in an area with which I am more familiar, since I am relatively new to Alabama, but not to the South, however.

I think, to be realistic, we have to realize that the individuals whom we train at the University of Alabama aren't necessarily going to stay in the State of Alabama, so what I am saying applies not only to us here in Alabama, but in the South as a whole, and, actually, the whole country.

We need a program similar to Public Law 85-926 that will go into the areas particularly of neuromuscular and orthopedic disabilities and the allied areas of physical therapy and occupational therapy.

In the city of Birmingham there are only 10 registered physical therapists. If you are going to staff classes for children who have orthopedic difficulties, we are going to have physical therapists.

Another need as far as our program in Alabama is concerned is school psychologists, not from the standpoint of clinical psychology, but school psychologists for screening our children. Of course, the area of the gifted is not being touched.

The second thing we need is an increase in the number of fellowships and supporting grants which may be allocated to each State under Public Law 85-926.

In Southern States, as in Alabama, teacher training programs at the university level are either new or nonexistent, and the demand for trained individuals is great. Consideration of similar legislation which would have as its objective the training of teachers of retarded children would help to alleviate the acute shortage of trained teachers in classrooms for the educable mentally retarded in Alabama.

The 1958-59 educational status for all teachers of exceptional children in Alabama was as follows:

Master's degree: 33, or 13 percent.

Baccalaureate degree: 161, or 61 percent

Total number with degrees: 194, or 74 percent.

Three years' college: 16, or 7 percent.

Two years' college: 27, or 10 percent.

One year's college: 25, or 9 percent.

Total number without degrees: 68, or 26 percent.

In regard to the professional status of teachers, there is a limited number who have degrees in the whole specific area of special education in which they teach.

At the present time, the State department of education, through State Superintendent of Education Frank R. Stewart, and in cooperation with the State Committee on the Education of Exceptional Children, Mrs. Alpha Brown, consultant, Program for Exceptional Children, and the Bureau of Educational Research, University of Alabama, is in the process of determining the educational and professional status of teachers presently employed as teachers of exceptional children in the State of Alabama. A copy of the questionnaire is attached.

(Questionnaire referred to follows:)

AN INVESTIGATION TO DETERMINE THE EDUCATIONAL AND PROFESSIONAL
STATUS OF TEACHERS PRESENTLY EMPLOYED AS TEACHERS OF EXCEPTIONAL
CHILDREN IN THE STATE OF ALABAMA

This EDUCATIONAL AND PROFESSIONAL STATUS STUDY is being done through the State Department of Education in cooperation with the State Committee on the Education of Exceptional Children, Mrs. Alpha Brown, Consultant, Program for Exceptional Children, and the Bureau of Educational Research, University of Alabama.

As a part of this study, the transcript of each of the 305 teachers of exceptional children employed in the state during the 1959-60 school year is to be checked for specific course work in the areas of special education. Your cooperation is necessary for completion of this study.

Dear _____

Please indicate below whether or not you have had additional course work since your transcript of credits was sent to the State Department of Education for certification.

Circle one: 1. Additional course work has been taken which has not
been sent to the State Department of Education.

2. No additional course work has been taken.

If you circled Number 1., please name the college or colleges in which work has been taken:

You are hereby requested to sign the authorization below which will authorize the State Superintendent to request complete transcripts from colleges or universities in the State of Alabama.

Should your work have been taken outside the State of Alabama, will you please have the institution send a complete transcript of your work to the State Superintendent of Education, State Department of Education, Montgomery, Alabama.

I hereby authorize the State Superintendent of Education to request a transcript of credits from:

The course work was done under the name of _____

Signature

Address

Date

EDUCATIONAL AND PROFESSIONAL STATUS STUDY

I. HIGHEST EARNED DEGREE

- Circle One:
1. Baccalaureate Degree
 2. Masters Degree
 3. Two-Year Graduate Certificate
above Masters

II. TEACHING SITUATION IN WHICH TEACHER EMPLOYED

- Circle One:
1. Ungraded or multi-graded class in a regular day school for children with various kinds of handicapping conditions including children with cerebral palsy.
 2. Ungraded or multi-graded special class in a regular day school ONLY for children with cerebral palsy.
 3. Ungraded or multi-graded special class in a regular day school ONLY for children who are mentally retarded.
 4. Special day school for crippled children of retarded mental development.
 5. Special day school for children with retarded mental development.
 6. Special day school for children with various handicapping conditions.
 7. Center comprising two or more special classes for crippled children in a regular day school; i. e., a special wing attached to a regular school.
 8. Hospital.
 9. Homebound.
 10. Residential school for crippled children.
 11. Residential school for retarded children.
 12. Other type residential school. Please explain:

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13. Multi-graded classes forming a center for cerebral palsied children in a regular school.
14. Speech Therapy.
15. Hearing Therapy.
16. Other. Please explain: _____

III. COURSES YOU HAVE HAD WHICH YOU FEEL ARE PARTICULARLY HELPFUL TO YOU
IN YOUR TEACHING OF EXCEPTIONAL CHILDREN

Please list those courses and indicate how they were given.

Examples:	List of Courses	How Given
	1. Survey of Exceptional Children	Campus class
	2. Tests and Measurements	Extension
	3. Mental Health	2-week Workshop

LIST OF COURSES

HOW GIVEN

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IV. CONCEPTS WHICH ARE NEEDED IN WORK WITH EXCEPTIONAL CHILDREN

CODE

- 0. Not included.
- 1. Not included directly, but by transfer or by implication, some help from courses taken.
- 2. Included to a minor extent by direct attention.
- 3. Considerable help by direct design, purpose, or attention.
- 4. Much help from courses or units specifically presented for that purpose.

For each item below, circle the one number in the series to the left which by the code best describes the extent to which the item was presented in courses you have taken.

- 0 1 2 3 4 1. Methods and materials for teaching children with cerebral palsy
- 0 1 2 3 4 2. Methods and materials for teaching children with retarded mental development
- 0 1 2 3 4 3. Internship (directed teaching) with various categories of exceptional children
- 0 1 2 3 4 4. Psychological evaluation of exceptional children
- 0 1 2 3 4 5. Parent counseling
- 0 1 2 3 4 6. Medical aspects of crippling conditions
- 0 1 2 3 4 7. Medical aspects of mental retardation
- 0 1 2 3 4 8. Speech Correction
- 0 1 2 3 4 9. Information concerning the brain-injured child, both with motor and non-motor involvement.
- 0 1 2 3 4 10. Orientation to materials and methods in occupational therapy

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- O 1 2 3 4 11. Orientation to materials and methods in physical therapy
- O 1 2 3 4 12. Information in the area of pre-vocational and vocational rehabilitation
- O 1 2 3 4 13. Special equipment for orthopedic classrooms
- O 1 2 3 4 14. Information on how to relate the special class program to the community
- O 1 2 3 4 15. Field trip experience with exceptional children
- O 1 2 3 4 16. Methods of teaching mentally retarded children
- O 1 2 3 4 17. Instruction in arts and crafts
- O 1 2 3 4 18. Instruction in subject area fields
- O 1 2 3 4 19. Administration of vision screening tests
- O 1 2 3 4 20. Administration of hearing screening tests
- O 1 2 3 4 21. Information concerning the emotionally disturbed child
- O 1 2 3 4 22. Measurement and evaluation of progress of exceptional children
- O 1 2 3 4 23. Instruction in the area of remedial reading
- O 1 2 3 4 24. Instruction in the area of remedial teaching of subject matter
- O 1 2 3 4 25. Methods of teaching the partially sighted
- O 1 2 3 4 26. Information on how to teach the normal child
- O 1 2 3 4 27. Information on how to teach the multiply-handicapped child
- O 1 2 3 4 28. Information on convulsive disorders (epilepsy)
- O 1 2 3 4 29. Classroom control of exceptional children
- O 1 2 3 4 30. Information in the area of research methods
- O 1 2 3 4 31. Information about group therapy methods
- O 1 2 3 4 32. Information on articulation and integration of special class programs with those of the regular classrooms

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- 0 1 2 3 4 33. Audio-visual education
- 0 1 2 3 4 34. Child development
- 0 1 2 3 4 35. Information in the area of play therapy
- 0 1 2 3 4 36. Information on how to teach the deaf
- 0 1 2 3 4 37. Information on how to teach the hard-of-hearing
- 0 1 2 3 4 38. Music and/or music therapy for the handicapped
- 0 1 2 3 4 39. Courses in mental hygiene
- 0 1 2 3 4 40. Information in the area of aphasia
- 0 1 2 3 4 41. Information in the area of health education
- 0 1 2 3 4 42. Information concerning drug therapies for the various types of exceptionalities
- 0 1 2 3 4 43. How to teach typewriting
- 0 1 2 3 4 44. Information concerning the child with cardiac involvement
- 0 1 2 3 4 45. Information in the area of semantics and its application to the fields of exceptionality
- 0 1 2 3 4 46. Information regarding records for children who are classified as exceptional
- 0 1 2 3 4 47. Interpretation of medical, social, and psychological reports
- 0 1 2 3 4 48. Others. Please list: _____
- 0 1 2 3 4 _____
- 0 1 2 3 4 _____
- 0 1 2 3 4 _____
- 0 1 2 3 4 _____
- 0 1 2 3 4 _____
- 0 1 2 3 4 _____

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V. AREAS IN WHICH YOU FEEL THE MOST URGENT NEED FOR HELP

Circle the items noted in IV., above, which you feel indicate your most urgent need for help. Indicate this need by circling the item number in IV.

Example: (0) 1 2 3 4

(9.) Information concerning the brain-injured child, both with motor and non-motor involvement

Circling of 0 indicates that this area was not included in past course work.

Circling of 9. indicates that you feel an urgent need for help or information in this area.

Circle not more than 15.

For consideration: There are five related areas, not specifically concerned with the educational and professional status of teachers presently employed as teachers of exceptional children, which would be of help to the State Committee in giving insight and information into the kinds of teaching and programs which now exist.

I. OPPORTUNITIES WHICH CHILDREN IN YOUR SPECIAL CLASS HAVE TO ASSOCIATE WITH CHILDREN IN REGULAR CLASSES

Please check, YES or NO, the opportunities afforded children in your special class.

YES NO

- | | | |
|-----|-----|---|
| ___ | ___ | 1. Share cafeteria with other children at the same times |
| ___ | ___ | 2. Share auditorium with other children at the same times |
| ___ | ___ | 3. Share playground with other children at the same times |
| ___ | ___ | 4. Joint parties |
| ___ | ___ | 5. Visit regular rooms |
| ___ | ___ | 6. Regular rooms visit with special class |
| ___ | ___ | 7. Children included in regular class programs where articulation is possible, i. e., the orthopedically involved children have some class work in a class with regular school children |

8. No formal efforts are made to give exceptional children the opportunity to associate with children in regular classes

9. Other. Please specify: _____

II. INFORMATION REGARDING OFFICIAL WRITTEN RECORDS

A. Kinds of records	Available		Recorded by whom?	Where are these records kept on file?
	Yes	No		

- | | | |
|-------|-----------------------------|-------|
| _____ | a. Medical | _____ |
| _____ | b. Psychological | _____ |
| _____ | c. Social | _____ |
| _____ | d. Achievement Scores | _____ |
| _____ | e. Hearing | _____ |
| _____ | f. Vision | _____ |
| _____ | g. Speech | _____ |
| _____ | h. Physical Therapy | _____ |
| _____ | i. Occupational Therapy | _____ |
| _____ | j. Play Therapy | _____ |
| _____ | k. Dental | _____ |
| _____ | l. Progress reports | _____ |
| _____ | m. Staff conference records | _____ |
| _____ | n. Guidance center records | _____ |
| _____ | o. Anecdotal records | _____ |
| _____ | (1) objective? | _____ |
| _____ | (2) Subjective? | _____ |
| _____ | p. Other. | _____ |

Please specify:

3. Please check which of the above records are available to you as a teacher. Check to the left of the items in A. above.

Example: It is possible that n. Guidance center records are available, yet are not available to you as a teacher.

III. INTERACTION WITH PARENTS

Please check YES or NO to each of the following:

YES NO

- | | | |
|-----|-----|--------------------------------------|
| ___ | ___ | 1. Volunteer help in the classroom |
| ___ | ___ | 2. Transportation to and from school |
| ___ | ___ | 3. Transportation on field trips |
| ___ | ___ | 4. Obtaining teaching materials |
| ___ | ___ | 5. Home training--academic |
| ___ | ___ | 6. Home training--therapeutic |
| ___ | ___ | 7. Organized parent group |
| ___ | ___ | 8. Public relations |
| ___ | ___ | 9. Parent-teacher conferences |
| | | 10. Other. Please specify: _____ |

IV. PROFESSIONAL READING

- A. Journals; i. e., Exceptional Children, Journal of Mental Deficiency, etc. Please specify:

- B. Books; i. e., Kirk and Johnson, Educating the Retarded Child, etc. Please specify.

- C. Other. Please specify: _____

V. MATERIALS OF INSTRUCTION

List special equipment and types of materials of instruction available to your class. Describe in terms of major categories such as books, audio-visual aids, art supplies, etc. (If necessary, use back of this sheet to complete listing.)

**EMERGENCY PROGRAM TO PROVIDE OPPORTUNITIES FOR TEACHERS NOW WORKING IN
SPECIAL EDUCATION TO BECOME BETTER QUALIFIED**

Objective: The general objective of the program would be to provide expert help and instruction for teachers now serving as classroom teachers of the mentally retarded and multiple handicapped.

Scope of program: The scope of the program would be statewide in that the State would be divided into areas for the offering of course work which could be used toward a degree program. Such areas would be designated by committee or subcommittee decision. Program time: 3 years.

(1) Areas could be based upon AEA districts, and would be as follows:

White:

- District 1, 25 teachers;
- District 2, 5 teachers;
- District 3, 28 teachers;
- District 4, 20 teachers;
- District 5, 77 teachers;
- District 6, 29 teachers;
- District 7, 29 teachers;
- District 8, 41 teachers.

Negro:

- District A, 26 teachers;
- District B, 18 teachers.

Designation of areas should consider the availability of plant facilities.

(2) Personnel should include a minimum of three full-time instructors plus one full-time secretary to coordinate the business affairs of the program. The inclusion of consultant service from recognized authorities in the various areas of exceptionality on at least a once per year basis is strongly recommended.

(3) Budgeted items should include:

(a) Salaries for three instructors whose minimum qualifications would be a masters degree plus experience in area taught. Ed. D. or Ph. D. degree level would be preferable.

(b) Salary for full-time secretarial help.

(c) Expenses, travel, and honorarium for consultants.

(d) Provision of library for each of the three instructors, plus consideration of similar libraries for those permanently attached to universities now offering programs and who, it is assumed, would be used to service areas.

(e) Maintenance and travel for three instructors, to include visitation in classrooms of teacher-trainees.

(f) Office expense, basic space and materials to be provided by the housing institution.

BUDGET (PROPOSED)

SALARIES

Instructors (3), minimum qualifications: Master's degree with actual teaching experience in area(s) of special education taught, 9 months' salary-----	\$-----
Secretary (1), fulltime, to serve instructors in the field, 12 months' salary-----	\$-----
Consultants, minimum of 2 per school year (September-May)-----	\$-----
Other-----	\$-----
-----	\$-----
-----	\$-----
-----	\$-----

MAINTENANCE AND TRAVEL

Per diem, at \$9 per day (proposed classroom visitation of each teacher-trainee once per semester)-----	\$-----
Travel, at 8 cents per mile (proposed classroom visitation of each teacher-trainee once per semester)-----	\$-----
Other-----	\$-----
-----	\$-----
-----	\$-----

OFFICE EXPENSES

Provision of office space and usual office supplies and expenditures to be provided by the housing institution.

Additional equipment and expenditures-----	\$-----
Other-----	\$-----
-----	\$-----

LIBRARY

Due to the nature of the program, each instructor would need a library facility which he could take with him. There would be an initial outlay for each instructor with provision for additional purchases as needed and as new materials become available.

Initial outlay-----	\$-----
provision for new and/or additional materials-----	\$-----
Other-----	-----
-----	-----
-----	\$-----
-----	\$-----
Total projected cost per year-----	\$-----

Total projected cost per year: \$49,166.

Mr. HARVEY. The mentally retarded child accounts for approximately 71 percent of all children in special classes in Alabama for the current school year.

In Alabama the need is for:

(a) Fellowships for graduate level study and for supporting grants to institutions which will allow a building up of the professional group. The problem is not one of replacing people; it is the very real problem of initial placement.

(b) Undergraduate fellowships for the third and fourth undergraduate years to aid in recruitment and training of teachers for the mentally retarded.

I think some of the people in professional education are beginning to call this the retread program of taking people who have gone through a regular 4-year program either at the elementary or secondary level and then superimposing training in the area of special education, or a certain area. We must start at the undergraduate level.

(c) Additional classes in the public schools. There are an estimated 100,000 exceptional children, ages 6 to 20, white and Negro, in Alabama. Of that number, some 4.6 percent now are being provided noninstitutional special education.

Mr. ELLIOTT. Let me get that point, Mr. Harvey.

We have 100,000 exceptional children in Alabama, and we are providing a program of special education for 4,600 of them; is that right?

Mr. HARVEY. That is right, 4,600. Three thousand and seven hundred of those children are in classes for retarded children; 900 of them are in other categories, mainly physically handicapped.

Mr. ELLIOTT. So when we brag on ourselves about what we are accomplishing and look at it from the standpoint of the fact that we are serving less than 5 percent, we have a good, long way to go, haven't we?

Mr. HARVEY. We have a tremendous way to go.

I do feel, though, that Alabama has done a wonderful job, I think I can be objective about this since I have just come to Alabama, a better job than most people give us credit for having done, because

other States that have been in the program for a number of years, 10 or 15 years, are servicing no more than 8 to 10 percent of these children.

Mr. ELLIOTT. What is the national average of educational service to exceptional children?

Mr. HARVEY. Well, it would vary, of course, from State to State, but I think on a national level we would not be talking much more than 12 to 15 percent. I do not know that I have ever seen this figure, but it is low.

Mr. ELLIOTT. You would estimate that the national average would be 10 or 12 percent, and in Alabama we are doing about 4.6 percent?

Mr. HARVEY. Yes, sir.

The problem of additional staff at the State level has been mentioned by a number of people who appeared before the committee, but I do think we do need additional people both as supervisors and to serve as consultants in the various areas.

The one individual at the State level has done a very creditable job, but you can't do all of it by yourself.

(d) Additional staff at the State level; both to provide supervision and to serve as consultants.

(e) Building needs are great. There is need for funds to provide special wings and/or rooms to provide adequate facilities for exceptional children.

(f) Transportation needs in the rural areas and for crippled children are not being met.

Dr. Neil referred to this as one child in one community and another in another community. This has been run into before and it is a very difficult thing to handle.

If a good transportation system could be worked out for cooperative programs, we can service these children even in a State as basically rural as Alabama.

I think one thing that has not been mentioned is that on the positive side the State department of education has taken a step that no other State has taken. There is a State committee which has begun a plan for coordination of the State institutions of higher learning, namely, the two universities and the four State colleges.

This program of teacher education for exceptional children is an expensive thing. We have to face that, that it is expensive. Also, the securing of the trained staff is even more of a problem here. This is recognized and steps are being taken.

I think some very basic agreements which have just recently been reached will allow us to coordinate our training program and come along from that level. If we get a little help from the Federal Government, such as Public Law 85-962, we are going to make some real progress in Alabama.

Thank you.

Mr. ELLIOTT. We need to expand that public law for the mentally retarded so as to get a training program under way for all these categories for teachers, do we not?

Mr. HARVEY. We surely do.

Mr. ELLIOTT. That is the bare minimum.

We are spending \$1 million a year to get this program started for the mentally retarded. Maybe this is not a fair question for you, but

do you have any estimate as to how much it would cost to expand that teacher training program sufficiently to begin to train teachers for all categories of these special educational needs?

I do not know, myself, what it would cost. I have an idea that the figure would be fairly significant, but certainly something that we have to do, as I see it.

Mr. HARVEY. I really would not know how to estimate that. I think that we have been pointing out this thing of recruitment as being a real problem. The people who come to my office almost daily and discuss interest in the area of exceptional children have families, they are tied up in situations, and fellowships will help us here. The people are interested if we can work through something at this level.

Mr. ELLIOTT. Thank you very much, Mr. Harvey, for your kind testimony.

Mr. ELLIOTT. Our next witness is Douglas Carter, exceptional child chairman of the North Carolina Congress of Parents and Teachers, Charlotte, N.C. Is Mr. Carter here?

If not, our next witness is Mrs. Joan S. Bergman, chief therapist, physical medicine department, University of Alabama Medical Center, Birmingham, Ala.

We are very happy to have you, Mrs. Bergman, and we are anxious to hear what you have to testify to us. You may proceed as you wish.

STATEMENT OF MRS. JOAN S. BERGMAN, CHIEF THERAPIST, PHYSICAL MEDICINE DEPARTMENT, UNIVERSITY OF ALABAMA MEDICAL CENTER, BIRMINGHAM, ALA.

Mrs. BERGMAN. Thank you.

I have been invited here today as a representative of the qualified physical therapists here in Alabama. I am afraid I am going to do what Mrs. Thiel has said. I am going to bombard you with all of our needs.

I think the best way to tell our story is to take a look at the overall picture here in Alabama.

In 1958, the State of Alabama had a population of 3,220,250. According to our national standards, there should be 1 physical therapist for every 10,000 people. This means, of course, that there should be 322 therapists working full time in Alabama. There are 41.

Mr. ELLIOTT. 322 and we have 41?

Mrs. BERGMAN. Several of those are working part time.

Mr. ELLIOTT. And when you take the 7 part time off, we have 34; is that right?

Mrs. BERGMAN. Yes.

To become even more specific, Birmingham, proper, has a population of 378,000, and Metropolitan Birmingham has a population of 640,000. This would give us enough work to keep 64 therapists busy. We have seven working full time, three part time, and one who travels and is in the area part of the time. Actually, there are only three centers of physical therapy in Alabama. These are in Birmingham, Montgomery, and Mobile.

Any person who happens to live in an outlying area, must either travel to one of these centers for treatment or go completely without the care that they deserve.

Mr. ELLIOTT. Let me ask you this question, Mrs. Bergman: The trend in this country now is to build everything in the centers of population. They say that if you need a hospital that is any size, that it ought to go to Birmingham, in our State, and if you need the specialties, the special type hospitals, that they ought to be built around the medical center.

I know you will pardon me if I inquire, and you may not be qualified to answer this question, how folks out here in the hills that are anywhere from 120 miles to 40 miles away are going to get the benefits of those services that are concentrated in the cities.

I do not know what the solution to it is myself. We have a good program of building small Hill-Burton hospitals over our State, but now the Veterans' Administration, for instance, I have heard officials of the Veterans' Administration say that if you build a VA hospital in the small town, you cannot induce personnel to come to the small town to operate the hospital.

It seems to me that if you follow that line of thinking right to its logical conclusions, before long we are going to all finish up in the city. I think there must be some other solution than that.

Mrs. BERGMAN. As far as physical therapy is concerned, I believe there should be big rehabilitation centers in your larger places, in Birmingham, Montgomery, where people can come and stay and get intensive care. But this does not take care of physical therapy.

Each hospital really needs a department. Each person who has a simple knee operation deserves maybe one or two treatments. Then they would have a good knee.

We need therapists in all of our small places and then more and larger facilities, too. We don't have the therapists to put out in the small places.

Mr. ELLIOTT. In the cities you do not have enough to divide with the rural areas, do you?

Mrs. BERGMAN. We do not have enough for our cities. I know in Florence, last year, they raised quite a bit of money to equip a physical therapy department. I worked with them on this. The whole community was very enthused. They raised the money, they equipped the department, and they have not gotten a therapist yet. So it is wasted. This has happened in several places. I hope that we can help them staff it. We keep trying.

I would like to tell you about my own department. It explains a little more about the State as a whole. This is the physical medicine department of the university hospital, which is a part of the University of Alabama Medical Center. It was reopened for patient care on January 3, 1956. Prior to this date there was no facility for the care of the general public in Birmingham, which, again, is a city of 640,000 people.

In our department, we render care to all patients, whether they be private, part-time, agency, or indigent.

In the 4 years that we have been open, we have treated patients from 57 of the 67 counties in Alabama, and from 10 other States.

We started by giving 4 treatments the first week and now we average slightly over 100 per week.

While this is a very small beginning in physical medicine, we feel that we have made a significant contribution to the rehabilitation of many people.

These last facts sound very good to us, we are very proud of them. But will we continue to grow?

Our problems of course go back to the supply and demand that you always run into. Our first problem is the demand or the education of the public and the physician to the importance of physical therapy. You see, the word "rehabilitation" means something only to those who understand the well. We are slowly overcoming this problem.

Using our own department as an example, we have had 149 different physicians prescribing treatments for patients. This number continues to grow slowly, but it is a steady growth. Little by little with the existing department showing what can be done, more physicians are requesting treatments for their patients. Having a facility utilized to its full potential is a problem, but one which we can tackle on the local scene. Handling the other phases of the problem is a bit more difficult.

It is a gross understatement to say that there are not enough facilities offering treatment in physical medicine. Certainly we hope that the Government will not cut down the funds available to help build these centers. Even if we were to get these centers, we would still have the shortage of personnel to contend with. More scholarships and more grants for the training of therapists are needed, but I do not see how we can really alleviate this shortage until we begin training qualified personnel here in our own vicinity.

In the past 5 years I have seen many people recruited and counseled, and have seen them go off to school to study physical therapy. There being no school in this part of the country, they must go away for training. Only one has returned.

Mr. ELLIOTT. Where is the closest physical therapy school?

Mrs. BERGMAN. The closest one is in Columbus, Ohio, 475 miles from Birmingham.

Mr. ELLIOTT. The closest one is 475 miles away?

Mrs. BERGMAN. Yes.

The next two are in St. Louis, and they are 490 miles from Birmingham. We don't get them back. They see other parts of the country and stay.

Mr. DANIELS. Why is that?

Mrs. BERGMAN. Physical therapists are a very wandering bunch. I think the main reason is there is a demand for them all over the country, just as there is here in Alabama.

Mr. ELLIOTT. You mean our northern neighbors can pay them more money.

Mrs. BERGMAN. No, but if you have a southern person and you send them away, they decide they would like to see Seattle, maybe, and they can always go any place in the country and work for a year and then go some place else and work for a year.

The physical therapists travel. Our national association cannot keep up with the ones that roam around. They are supposed to be

the most roaming professional people. So you can see that we feel we must have a school here.

If we can keep them here and train them here, it would be better.

The University of Alabama Medical Center is an ideal location for a school. This is not only my opinion and the opinion of the personnel in the center and of the therapists in Alabama, but this is also the unofficial opinion of the executive staff of the American Physical Therapy Association.

I will have to admit this: Physically, our department consists of seven rooms in the most deplorable condition. We would have to have a better facility if we were to train top-notch therapists. We will not go into the training of therapists until we can be sure that we will be turning out good ones. Of course, we need classrooms and teaching equipment.

Before leaving, I would also like to say that as a member of the rehabilitation team I cannot express strongly enough my hope that the independent living bill will be passed. We see patients every day that would benefit from this and who deserve the care that it would provide.

Mr. ELLIOTT. I happen to be, by virtue of these people electing me to Congress time after time, one of the people who passed Public Law 565, and I thought that it made a very great contribution in that field. That was in 1955, I guess, or 1956. But I think that our experience under that has taught us, plus the growth in the spirit of our general thinking about our human needs, that we have to do something else in that field.

My independent living bill is my approach to that, but I am looking for suggestions constantly from people like you, whereby we can improve upon the structure of that bill.

I am glad you think it is good.

Mrs. BERGMAN. I do.

Mr. ELLIOTT. Thank you so much.

Mr. DANIELS. I have one question.

Your testimony indicates you have given this subject quite a great deal of study. Have you formulated any opinion as to how much it would cost to fully equip a first-class therapy laboratory clinic?

Mrs. BERGMAN. Well, I wouldn't let my boss come down with me. I have floor plans drawn for every place in the hospital. If they say, "You can move to the second floor," I have the drawing.

We are hoping to be renovated and moved into a new part of the hospital soon, and we are working on lists of costs of equipment, including teaching equipment and renovation so that we would have a nice facility. This, incidentally, would be the beginning or nucleus. The long-range program would consist of this department of physical therapy. It is called the physical medicine department, but it is only physical therapy.

In our budget we already have room for occupational therapy as soon as we can get floor space. Then the medical center is planning an ambulatory patient center and we would have a regular rehabilitation center there, with all of the different parts of physical medicine and, of course, physical therapy in the center.

Our little department that I am planning now would serve for the inpatients and for the beginning of the teaching. A very rough esti-

mate, and we have not finished our lists yet, would be that it would cost us somewhere from \$30,000 to \$40,000 to set up just the inpatient department in the hospital.

Mr. DANIELS. I do know that back home in my county we have a mental disease hospital which 2 years ago installed a physical therapy department just for the inpatients of the hospital. And, if my recollection served me correctly, it cost about \$40,000. It is supposed to be one of the most up to date and efficient therapy departments around.

Mrs. BERGMAN. I wish we had it.

Mr. ELLIOTT. Thank you very much.

I see my friend Raymond Higdon in the room. He is the county tax collector. He knows all about rehabilitation and is interested in it.

We are glad to have you here, Raymond, to show your interest.

Our next witness is Miss Virginia Dobbin, from the recreation department of Bryce Hospital, Tuscaloosa, Ala.

Miss Dobbin, we are happy to have you.

STATEMENT OF VIRGINIA DOBBIN, RECREATION DEPARTMENT, BRYCE HOSPITAL, TUSCALOOSA, ALA.

Miss DOBBIN. I am here as a representative of the consulting service on recreation for the ill and handicapped of the National Recreation Association, with regard to their interest in the bill for independent living.

This is very close to the heart of recreation people because we do live in a social world, and all of our relations are social relations.

The way we interpret the world comes from the way we have built up our own idea of self and our own idea of self comes from what other people think of us, or what we think they think of us.

So self becomes the frame of reference for each person. Because the world and other people are interpreted in this manner and understood in this manner, it becomes a social concern that we build up desirable selves in each person.

One of the great fallacies in thinking is that all men are created equal, free and equal. It is quite apparent from birth on there is a great difference in individuals, and then due to various things that happen other differences enter.

When a step is taken to provide equal opportunity, effort must be made to relate the opportunity to the variances in capabilities. We feel that the bill for independent living is the chance for doing this.

When we speak of handicapped individuals who are we talking about?

We usually think first of the orthopedically incapacitated person. But then what about Franklin Delano Roosevelt. We think of the deaf, but what about Beethoven?

Old age has entered into the picture and becomes a problem.

What about Grandma Moses, 99, painting world famous landscapes.

One of her paintings just recently sold for \$3,400.

But these are the fortunate ones, the ones who are able to accept themselves.

What we have to do in our job is to reach out to these others who have not been able to accept themselves and help themselves to reach the same goal, not world fame, but a place in the world, the world of people.

The disabled have a very deep need for acceptance and understanding, because they rely so much on other people they develop a very sensitive reception to what the person is thinking about them.

The road to independent living is a mighty long one. It seems that up to now we have tried to play the old game of giant steps to get to the end of it, which is vocational rehabilitation.

Now, we have to go back and pick up the ones that we left along the roadside. How can we help?

Well, as a representative of the National Recreation Association, I would like to point out three large areas that we feel recreation could help in.

In playgrounds and other recreational facilities equipped to care for the handicapped child, insofar as I have been able to ascertain, there are no public playgrounds within the State to train leadership in specialized equipment to provide this service.

What could this mean to the child?

Well, the most enduring need of a child is the need to be loved, to belong, to give and to receive, to cooperate, and to be accepted by his own age group.

This applies to the deaf child, the one with cerebral palsy, the blind, the lame, and the mentally retarded as well as the normal.

But could they find this today?

Another large area is in hospitals. From a study conducted by the National Recreation Association in 1958, we find that there are, in Alabama, 129 hospitals that are registered with the American Medical Association. Out of these 129 hospitals, 19 have organized recreation programs with professional staffs.

In speaking of hospitals, most people think of the general hospital. Here we find the child so often full of insecurity at being away from home for the first time, with all the unfamiliar hospital routine. How much the family play patterns could do to allay his fears. Play periods bring relaxation, relief from pain, and a minimum of crying.

To an adult, convalescent means a major change in his pattern of life and his way of meeting needs.

The hospitalized person has a world that becomes small, and he becomes self-centered, he needs activities to draw him away from self.

Many realize that due to the nature of their illness they will not be able to continue some of the hobbies and sports that once filled their leisure time. This could be a time for finding new interests and new skills with the help of trained leadership.

The child or adult in a TB hospital faces a long period of hospitalization with the need for relaxation of paramount necessity. This is at the very time when all the activities which filled his day have suddenly ceased. Relaxation is an art and not many persons have become skilled in it. It can be encouraged through music, art, reading, learning new skills.

The child, even though he is in a TB hospital, needs to experience in a limited way the same experiences that are common to his age group.

The adult must have creative and social experiences related to the happenings in the world.

The same holds true for the orthopedically incapacitated patient. Not just a problem of arms, legs, and backs. It is the problem of the whole person, because human movements are the principal outlet for energies, the tensions are high for the disabled who are inactive.

Then, of course, to me the big field of hospital recreation lies in the mental hospital. Here we find the person who, regardless of the type of illness, has failed in social relationships. This means that the recreation personnel are challenged to provide activities that are not just pastimes, to fill the waking hours and break the monotony of hospital routine, but which are the means of providing those linkages with life that H. A. Overstreet talks about in "Mature Mind," helping him find new knowledge about himself and the world about him; helping him journey from irresponsibility to responsibility; helping him to become articulate, to escape a skin-enclosed suffocation.

The means of measuring this, of course, vary with the leader and with the individual.

But in the recreation program within the hospital lies the chance for the patient to once more enter the world of reality and to take his rightful place as a social being.

The third large area where recreation could mean a great deal is in the nursing home program. There is an article in February issue of the *Altruism* magazine which tells of a project being conducted in Illinois. I am not sure whether you are familiar with it. I was not.

Here they found that 50 percent of the State's medical costs for public aid was being spent to maintain indigent oldsters in nursing homes. With assistance from the National Institutes of Health, the Illinois geriatric rehabilitation program was established, and at the end of the first 2 years, 80 percent of those selected had returned to community life.

The study showed that most older patients responded rapidly to psychological support, motor retraining, and medical treatment.

The more comprehensive the program, the more quickly the patient is on his own again.

Yet in checking with the Alabama Nursing Home Association, we find there is not a home in Alabama with a recreation program or recreation personnel.

We as an association would stress the need for grants for, first, research to evaluate the possibilities of recreation for the ill and handicapped, and the best methods in the field.

Second, demonstration projects in the field; and

Third, visual material which will ring the bell and tell the people what can be done and how it can be done.

Mr. ELLIOTT. Thank you very much, Miss Dobbin. Your testimony was very challenging.

Our next witness is Miss Roberta Morgan, of the Jefferson County Coordinating Council of Social Forces, Birmingham, Ala.

STATEMENT OF ROBERTA MORGAN, JEFFERSON COUNTY COORDINATING COUNCIL OF SOCIAL FORCES, BIRMINGHAM, ALA.

Miss MORGAN. I appreciate this opportunity to appear before the committee.

I represent a community council made up of private and public agencies, with interested people who are interested and we make studies of needs in the fields of health, welfare, group work, housing, and make recommendations and plans to help carry out those services, and to coordinate services when we possibly can.

Mr. ELLIOTT. To whom do your recommendations go?

Miss MORGAN. They go to our board and then perhaps the boards of individual agencies, sometimes to the Community Chest board, if it is to provide some money for some needed services.

They go to various places. They may go to a private foundation, where we think there is a possibility of getting some money for a needed service or for a demonstration service until such time as the Community Chest funds could be raised to provide that service in the community.

We also belong to a State conference informally organized and I think we have about 30 counties usually represented, of just ordinary people, some workers, private citizens, interested people, interested in community services in their communities.

We were very pleased when we first got copies of this bill on rehabilitation and independent living. It was really fresh air.

We found it really dramatic, with possibilities.

We would like to present a little different side. We have to be comprehensive. We are interested in all phases of the different types of agencies.

Mr. ELLIOTT. Miss Morgan, before you begin your formal testimony about those matters, let me say to you that it has been my feeling all along that the greatest force in America for improving these things that we are talking about here, is the human interest right in America's precincts.

As we try to legislate, we must be careful, always, to preserve and give that personal interest on the part of the citizens a full expanse in which to operate.

Miss MORGAN. Yes.

Mr. ELLIOTT. If we do anything, legislatively speaking, to kill that interest at the local level, then, as we say, we just spin our wheels; do we not?

Miss MORGAN. That is right; legislation which is imposed without understanding or support of the people has very little chance of developing really good acts for a long time at least.

There is a magic about the word rehabilitation. It inspires the average person in a local community to lend his interests, his time, and to give money toward helping disabled persons to realize some of their hopes for independent living.

Many localities have established or, with encouragement will establish, such services for the chronically disabled as visiting nursing services, homemaker services, and perhaps under the visiting nursing sometimes called therapists, that being true in Birmingham now, on an hourly basis which can be provided free or purchased by individuals or by rehabilitation funds, perhaps, or some other agencies.

With encouragement, these local people use their initiative in establishing limited facilities and in organizing volunteers for services, even to the point of each one help one, help your individual neighbor, local communities are receptive to ideas of responsibility for sponsor-

ing demonstration projects, for developing self-help and independent living for its older citizens, if foundations or other funds can be granted to supplement other local funds.

Any legislation provided for broadening and intensifying programs for rehabilitation, for independent living, where Federal funds will be available to States and thus to local communities, should have provision for a statewide advisory committee with broad representation of the various professions and lay members, and local committees and ad hoc committees in specific areas in the community.

Where there are already existing community planning councils these might serve as a sponsor for a local advisory committees on rehabilitation or independent living.

These committees, local and State, would serve as a clearinghouse for applications for Federal funds for demonstration projects, for workshops, and for facilities for evaluation and treatment.

There is a multitude of public and private agencies, national and local, associations and societies, which presently have limited authority, programs and funds for advancing the effectiveness of services to people who are disabled as a result of congenital effects, the effects of acute or chronic illnesses, or as a result of traumatic accidents.

These agencies and organizations have developed some valuable research.

Medical specialists in dealing with certain diseases, other special personnel who serve the social and the economic needs of persons so handicapped that they are unable to live independently.

There is considerable imbalance as between the number of agencies and the funds provided for services for people in these categories, and surely as between people affected by different types of disabilities.

Have we come to the point where there is such competition for the public and private dollar and for professional personnel in short supply that the very people we are trying to serve suffer from the lack of coordination on all levels, Federal, State, and local communities?

The waste of money, scarce professional personnel, and physical facilities may increase unless stock is taken of what we now have, how we are using what we have, and what cooperative and coordinated programs can be developed.

Here and there, there are instances, particularly on the local level, of the beginnings of cooperative planning and program operation for the chronically disabled.

Illustrations are: Comprehensive evaluation services, coordinated workshops—we have one in Birmingham which we are very proud of—and teams for the care and rehabilitative services for the homebound.

In Alabama the State vocational rehabilitation and the crippled children services have worked with local groups, really the ad hoc committees of community councils, in fostering cooperation and coordination in workshops, and in such programs as the aftercare and training of persons discharged from mental institutions.

It would seem a great advantage to have some trained generalists or community organization workers attached to the State rehabilitation agency for further experimentation and demonstration in this area.

They have several people on the staff in Alabama who are dedicated and who have a good deal of skill in working with the local community groups, but they have so many other administrative responsibilities, or they are counselors, that the adding of some people who know about community organization to really work in the field, in the State, as representatives, might be quite advantageous in considering the legislation under consideration and carrying it out, furthering it.

Do we not have the unprecedented opportunity for the Federal Government to provide legislation and funds not only to demonstrate, but to establish coordinated programs by involving, but without the absorption, the established public services involved in some phases of rehabilitation, and there are a good many, nor the loss of identity of private agencies, many of which have pioneered and all of which are dedicated in their attempts to aid the disabled toward rehabilitation and independent living?

From the local viewpoint, it would seem that instead of establishing separate evaluation centers for groups with various types for those affected by the various types of disabilities, we must concentrate on the establishment and the adequate professional staffing of comprehensive evaluation and treatment centers in a few localities, usually where there is a medical school.

The purpose of an evaluation is to enable the health, the rehabilitation, the social work, and educational personnel to begin and to carry through activities, sometimes mutual activities, which will help the person evaluated to solve his problem.

You cannot just have an evaluation center and drop it there. From such evaluation centers there would have to be teams made up of personnel from indicated disciplines to carry out the agreed upon plans of the physical, social, and other rehabilitative services.

The persons given evaluation, treatment, and recommended followup at these centers will live in communities, as you have said, isolated from the center, with very limited numbers of trained personnel available locally.

State rehabilitation services will probably need to have mobile teams to follow through in these home communities, and to help organize local teams.

In local communities where there are not always the professionally trained personnel, there are persons who can be trained to assist there as volunteers.

I think of the Red Cross nursing courses for the home care of the sick, and other people who would be able to give considerable service in carrying out the recommendations of the evaluation center.

It may be that regional education boards and the respective States, would consider the establishment of training courses, specially for personnel dealing with the chronically disabled on a coordinated basis, that is, in teams.

This training would also be for the generalists who may not need the technical skills, such as a therapist, a nurse, a teacher of the blind, or the deaf, would need, but who would have a comprehensive knowledge of causes and preventions of disabilities or their social and economic consequences, and how to effect teamwork, how to use personnel to the best advantage, and to recruit and use local volunteers.

The healthy trend that we note in Federal legislation in providing funds for research, health facilities, and so forth, for nonprofit agencies as well as public agencies, could be still more beneficial providing for the inclusion of private with public funds to carry out needed local services, especially in the area of local programs designed for independent living for the chronically disabled.

Mr. ELLIOTT. Thank you very much, Miss Morgan, for your very helpful testimony. We appreciate it very much.

Our next witness is Judge Talbot Ellis, of the juvenile court in Birmingham.

Judge, I know you have been before my subcommittee before, and you always bring such fine ideas that Mr. Daniels and I will be very happy to hear you for 10 minutes on our problems.

**STATEMENT OF HON. TALBOT ELLIS, JUDGE, JUVENILE COURT,
BIRMINGHAM, ALA.**

Mr. ELLIS. Mr. Elliott, Congressman Daniels, I am like Anthony, I believe. I really didn't come here to speak. There has been so much said already that I really meant to listen.

Then I was running away from something back at my court that would make a man jump out of a window, almost, so it is a relaxation to come up to Judge Kenneth Griffith's court in Cullman and meet with your fine committee.

You asked me to come as a witness some time ago. When I read exactly what you were considering on this House joint resolution, this bill, I did not believe it was in my backyard, and I do not think that it is now, except very indirectly.

Mr. ELLIOTT. Judge, I really wanted to hear you testify in order that I might ask you two questions.

The first is this: I want to know if you have made any study in Jefferson County or in Alabama, or elsewhere, for that matter, of the relationship between juvenile delinquency and the handicaps, physical and mental, to which our people are heir.

Mr. ELLIS. I could not give you any figures on it. I can see these kids go before me from day to day, and I can point out to you a number of famous cases that I have had, that other judges have had, that seem to grow out of physical handicaps.

The most interesting and the most famous one that I know of was a case Judge Schramm, judge of the juvenile court in Pittsburgh, Pa., who just died last December, had concerning a little boy named "Old Baldy." At about 6 years old, when his mother was at a PTA meeting, or something, their little boy pulled a pot of hot wash off of a stove and it landed on his head, and from there on he did not have a hair or a root left alive. Because of that physical disability, that boy did everything in the book there was to do and violated every law there was for a little boy to violate except murder.

If that kid was not physically handicapped, I will eat your hat, and yet, under the existing law regarding handicapped children and this aid to handicapped that you have been discussing here today, that kid would not be eligible for any help.

The funny thing is that the most expensive wig that money can buy—and you need not laugh, because this is a flesh-and-blood story—

the most expensive wig that Judge Schramm could buy and put on that kid's head cured him of his delinquency and he is a law-abiding man today. That kid was as proud of that wig as you are of your new Cadillac, if you have one.

Physically handicapped? Yes. It did something to that kid to be different from the rest of the kids, to such an extent that he would kick your teeth out if you got down low enough or he got up high enough and he didn't like what you said.

There is a child who has just gone through the court in Birmingham who was born with a defect. He had no enamel on his teeth and teeth turned sideways. Some dental work has made a difference between a law-abiding citizen and a thug out of that little colored boy.

So there certainly is a great correlation between physical difficulties that a child has and delinquency.

What the percentage is—I will not give you figures. I know you can take figures and prove anything with them.

As I said to the committee before, figures don't lie, but some liars can really figure.

If I say one other thing, Mr. Chairman, before I go on, I would like to back up what a worker of mine yesterday said before this committee, Miss Ethel Gorman—maybe you remember that prematurely gray young woman, who worked for me for 5 or 6 years in the court and just left me to go with the department of social hygiene—I got what she said and the last of what she said was two fields in which she said this committee could be of some help in this kind of work. I do not know that I should quote them; her statements are in. The last two paragraphs are the important part to me.

It seems to be pretty general, gentlemen, that the help that may be needed from the Federal Government might be considered as training help, or the training of personnel. I believe in States rights. I think, like Judge Griffith over there does, that, if the Federal Government could release certain sources of income, we States ought to do these things for ourselves, but the Federal Government is taking nearly all the money and does not leave any money locally for the local folks to do what ought to be done and what should be done.

If you are going to keep the money and keep on taking it, then I think you not only should, but that you have a responsibility to, do some of these things in the local community.

I was at a recent meeting in Birmingham, and I thought when I came up here today we might be talking about Congressman Green's House bill, 7072, or your House bill, 3464. By the way, whatever happened to them?

Mr. ELLIOTT. My bill was reported out by our subcommittee last August or thereabouts, and about that time I became ill and Congress adjourned around the 1st of September. It is now pending before our full committee. I am hoping at the next meeting of our full committee to call up that bill and to get it reported out.

Mr. ELLIS. And Congressman Green's 7072?

Mr. ELLIOTT. Well, as between the two bills, there is, I suspect, some considerable debate and discussion, perhaps, whenever the bills come before the full committee, but they will be before the full committee shortly.

Mr. ELLIS. Let me say two things further, Congressman, and if there are any questions I will be glad to answer them. I planted a seed at a meeting in Birmingham about 10 days ago, a seed that was planted by the very comprehensive study that was made under the direction of the coordinating council in Birmingham in 1954, and that was the need in our metropolitan area of a new, modern, and up-to-date juvenile detention facility within our multimillion-dollar medical center, which you are personally acquainted with.

That was recommended by the 1954 report of all the social agencies in our community. That has been recommended by me and a number of other people.

I realize it is something that will not just happen overnight. But, I repeat, if you cannot figure any way to release to the States some of the money you are getting on a national level, I sure would like to see in my old age the Federal Government build such a center in our medical center, where adequate doctors and the University of Alabama students could study "Old Baldy" and some of these cases that we deal with daily and find out how come Johnnie can't read or how come Johnnie does like he does.

Second, Congressman, I would like to report to you that the two bills that I just named by number have been endorsed by the National Council of Juvenile Court Judges, of which I am a member, and I was on the committee.

In Salt Lake City last summer, they approved, by resolution, Federal legislation for the establishment of a program for the training of qualified personnel in the delinquency field, and in the initiation of pilot projects and research programs on delinquency, and urged that the Congress enact appropriate legislation for this purpose.

The chairman of that committee was Judge Joseph Felton, from Salem, Oreg., the home State of your Congresswoman Green.

Without having anything to say, I have said too much. So, thank you very much for this opportunity.

Mr. ELLIOTT. Thank you, Judge Ellis. You always stimulate my thinking. I appreciate your kindness.

Mr. ELLIS. Thank you.

Mr. ELLIOTT. Our next witness is Mr. Charles F. Zukoski, president of the Jefferson County Coordinating Council of Social Forces, Birmingham, Ala.

Let me say to you, Mr. Zukoski, that we are very happy to have you. I am looking forward to what you may have to tell us.

STATEMENT OF CHARLES F. ZUKOSKI, JR., PRESIDENT, JEFFERSON COUNTY COORDINATING COUNCIL OF SOCIAL FORCES, BIRMINGHAM, ALA.

Mr. ZUKOSKI. Thank you, Mr. Elliott and Mr. Daniels. I am going to speak as a layman here, because I am a layman and have not the technical competence to speak of the many fields which have been brought to your attention today and yesterday.

I feel I have learned a good deal more than I am going to be able to contribute, and yet I think there are some things, from the point of view of the ordinary citizen, that can be said and may be of some value to the committee. I will try to say some of those things.

I am to devote myself largely to the matter of the structure providing this aid in which this bill is interested. I think that you have learned in the hearings you had, and out of your other experience, that there is a tremendous number of different aspects of this problem of the disabled. There are many diverse conditions which prevail throughout the country; there are many different ways in which these problems can be met.

I think it is one of the strengths of America that we have 50 States, all of which, publicly and privately, are experimenting in different ways in trying to meet these tremendous needs of the disabled and the handicapped.

I think that, to the extent that we can, we have to leave that as a matter for State and local solution. It has always seemed to me that Federal aid has two main purposes. One is to provide some money which, as Judge Ellis said, we do not always have available in the States and localities and which the Federal Government has in various ways collected and can provide, and the other is one of establishing standards.

I am not one who believes in States rights to the extent of ignoring the fact that the Federal Government, in providing or in establishing standards, has helped the States enormously throughout the country. I see all kinds of evidence of that in Alabama. I think that, in this matter of rehabilitating and educating the handicapped, there is certainly a lot of room for that, through the development of the Federal Government that is interested in that subject.

Nevertheless, I do believe that to a very great extent we have to do that locally and within the States. For that reason, I am interested in the structure of this bill. There are several titles.

Titles II and IV, as I understand them, appropriate money, or through other appropriations will make available money, to some designated agency of the States.

Title III, which deals with workshops and particular projects, apparently will provide that the Secretary will make the funds available to various approved projects.

Am I right in that assumption?

Mr. ELLIOTT. Yes.

Mr. ZUKOSKI. I think that the manner in which titles II and IV handle the matter is excellent, because I don't see how, given the need for dealing with this on a State and local basis, it would be possible for the Secretary to designate all of the ways in which the funds can be used.

With respect to title III and the workshops, I anticipate a tremendous demand on the Secretary's time, the time of his staff, and the time of the Department, in trying to analyze and reach some conclusions as to priorities for a multitude of different projects.

For that reason I would like to suggest for the consideration of the committee the desirability of some alteration in that title III, and the method of disposition, perhaps again making funds available to each State on the basis of some agency in the State studying the local requirements, the relative needs of these different agencies, public and private, who have appeared before you and who have tremendous claims on whatever money is available, and arriving at some element of priority.

I would also like to suggest, as Miss Morgan and others perhaps have suggested to you, the desirability of establishing some machinery for a citizens' advisory council or councils, perhaps one on a statewide basis within each State, that would be composed of people who have interests in these different specializations we have been talking about, and who would give to the State the benefit of knowledge from which a well-balanced program, taking into account the facilities we already have—and we have many of them in Alabama, as well as in other States—a well-balanced program of filling in and of developing and making progress in this overall field in which we are all interested.

I know the value of that kind of a council or committee, because we have had so many evidences of it in the work of our own organization. For example, take the case of our workshop for certain of the handicapped in Birmingham. This started as a workshop merely for the orthopedic cases.

Some years ago we got Mr. Wise and others of the State rehabilitation, vocational, and rehabilitation service, together with groups representing the blind, and with groups representing others of the handicapped, and that facility was expanded to include the blind and, later, to include the mentally retarded.

We have worked in the fields of providing facilities for the return of patients in the State mental hospitals on ordinary living, and we have worked there with both public and private agencies in the creation of a foster-home program, which is now functioning in Birmingham, and which is working on the return of those persons to productive and ordinary living, working with the State rehabilitation service.

We are working with the schools; we are working with the health department and other facilities.

In the field of aid to the hard of hearing and those with speech defects, we brought into play the public schools, and have established facilities in the public schools, special facilities for dealing with those exceptional children.

What I am saying is: As I can understand it, this is a problem of coordination and of selection of priorities and of recognizing and analyzing, first, all of the needs, and then determining what can best be done.

The Federal Government can give a tremendous impetus to this whole program through this bill, by providing some funds and in providing through the Secretary certain standards that should be met.

But I believe it would be very desirable to establish within the bill a system whereby funds would be made available to one or, possibly, two social agencies in each State, and that, with that, you have some machinery for a representative council of State citizens such as have, on a national scale, in one phase of the bill, a provision for a national advisory council.

I think you could have this on a local basis within each State, and that your money would be tremendously more effective that way.

Mr. ELLIOTT. Thank you very much, Mr. Zukoski.

Have you any questions, Mr. Daniels?

Mr. DANIELS. No. I wish to compliment Mr. Zukoski for his very critical analysis of this bill. I think your testimony will be very helpful.

Mr. ELLIOTT. He has done a good analysis of us for a long time, and we appreciate it.

Mr. ZUKOSKI. Thank you.

Mr. ELLIOTT. Our next witness is Dr. Warren Weil, of Birmingham, Ala.

Dr. WEIL. Thank you.

Mr. ELLIOTT. Let me say that we are happy to have you, Dr. Weil.

**STATEMENT OF DR. WARREN B. WEIL, PHYSICIAN,
BIRMINGHAM, ALA.**

Dr. WEIL. Thank you, Mr. Chairman.

I reflect Judge Ellis' point of view that he came to listen, because I did, too. My main reason in coming was to lend any encouragement I could to the passage of the legislation proposed for reasons which are less specific than many you have heard; there is just so much to be done that any help we get is going to be useful, and the sooner some comes, even if it is a little awkward in spots, the better off large numbers of people are going to be.

Any notes I have made in the last few minutes, and they are poorly organized, possibly. I have no idea of what has been said before, but after listening to a few of these witnesses, I am sure that you have a fairly comprehensive picture of what is being done and what needs to be done with regard to the opinions of the various individuals who head up the agencies and societies, organizations that have an interest in this problem.

As a physician, and speaking for myself only, I have read the bills over and I must confess I stayed a few minutes trying to figure out just how much money would be coming, and I decided I did not know about that and let it go by, because it looked like it would be all right.

I thought of the bills and how that would help me as a physician.

I would like to point out briefly some of the problems a physician has in dealing with the individuals that we think of as in need of rehabilitation.

You mentioned the problem of distance; that is a particular problem for people who have deficiencies of any kind that affect their health. No matter how we try to arrange it or no matter how encouraging we are, no matter what our plans are, the fact that it is several miles, not 100, but 20, sometimes, and there is no busline or no railroad, and the individuals have to depend on someone to bring them to where they can be seen and helped, is a tremendous problem.

It has its impact not only because it exists, but because it adds to the burden of the handicapped in that it adds time between the time that they start and the time that they accomplish something.

For those of us that have never experienced the limitations in the serious illness lasting a long period of time, the very fact that the goal is so distant it is going to be difficult.

It is easy to say, but hard to do to convince somebody that not within a month or 6 weeks, but in 4 years they will be able to resume some sort of activity that will make them independent unfortunately depresses most of them to start.

The ease with which some of the initial goals can be accomplished is a terrible thing which has to have consideration.

Another aspect of the people who are in need of what we call rehabilitation is the fact that there is a tremendous emphasis on the individual involved.

It isn't because the people who are interested in this field are not aware of the other problem, but they feel fortunate that they can help this one person.

But a consideration of the family unit is terribly important. I have seen many, many situations in which we have outlined such simple things as diet, or the needs for physiotherapy which can be performed in the homes on occasion, the need to study and learn simple things.

Just the problem of illiteracy is a tremendous handicap. I have had situations—I had a man with a stroke, as an example, and we were severely limited by the fact that there were whole family units in which there were no literate individuals. That makes for an extremely difficult situation in terms of rehabilitation.

That would not be so bad if it was unusual, but it is not unusual.

That is the tragedy.

So considerations of the family units are important.

I am not going to elaborate on anything further, but another area that would take a lot more time to talk about is the patient that has any one of a number of known psychotic, but nevertheless important, mental illnesses.

Mr. ELLIOTT. Such as what?

Dr. WEIL. The constitutional psychopath, the individual who, for want of a better term, considers things inadequate. They cannot utilize opportunities, for reasons that are not always clear, but very often are a distillation of both some physical disability, cultural lack of opportunities, cultural or economic depressions, and it adds up to an individual that comes to maturity in terms of their years without any of that get up and go that many of us have.

The older a person gets without starting, the harder they are to start.

There is no question about it.

Mr. ELLIS. What do you call the general field of inadequacy?

Dr. WEIL. Well, in more sophisticated society, we sometimes refer to them as neurotics. In less sophisticated society, we generally designate them as bums.

But neither of those is a fair statement because they are generalizations. It has to be a much more finite definition of the factors involved in creating this before you can do much about it.

I have had the experience, and I am afraid I am running over my time, of seeing people who are applying for disability benefits for one reason or another, who put the emphasis on their back, for instance.

I have two men in the hospital now. One of them is 49 and the other is 50. They both have the feeling that they are disabled, they have had a backache for many years.

Both of these men have been seen not only by myself, but by orthopedists, neurologists, and neurosurgeons. They have had the advantage, if it be that, of competent X-ray examinations, physical examinations. There is no organic illness to be found.

But nobody considers that they are mental cases.

However, both of these men are illiterate. I asked one man how far he had gone in school and he said, "The third grade, or at least I was in the third grade 1 day."

He can neither read nor write.

In the recent boom years, during the war, he was employed in an industry which has thousands of employees. He was given a weekly salary check, and he made what might be considered a pretty good living because there was not a keen appreciation of his deficits. This man will have great difficulty in establishing his disability on physical grounds, and unless there is enough understanding of people like this, and this man has enough of his grasp of his society and the community, to feel that it is necessary to justify his inadequacy on physical grounds, it takes a tremendous amount of effort to persuade a man, particularly like this, who is about 44 or 45, well, it would be, the one I am speaking about now I mentioned is 49, that there is any purpose or aim in him being anything other than physically disabled.

But these are problems that have to be faced.

I think the one phrase that I noted in the bill that I wondered about, and in fact I called up the office of vocational rehabilitation of the State to find out, was the definition of the term "employable age."

I think that any bill dealing with the physically handicapped and those that need rehabilitation for any reason should not be limited by a certain year. Presumably there is a year of 16, 18, 20, or something.

One of our big needs is to close the gap. The individual who is not going to get along because they haven't the intelligence, the physique, or the stamina, has to be recognized early, and services and treatment, evaluation and care, have to begin as soon as they can be begun, in order that this person would be delivered to a place where they will be useful, and where they can be less of a burden on everyone else as soon as possible.

This is an exaggeration, perhaps, but there is a tremendous enthusiasm for children. I think you know that.

I was stopped on the way up here by a bunch of eager, conscientious mothers, stopped by the State police, and it was a mothers' march for polio. But mothers do not march for their fathers-in-law.

There is a certain stagnation when you get past childhood.

If there is a gap between the enthusiasm and the facilities for children and then nothing is available until the person is somewhat older, the inertia that is yours during that time can be deadly in terms of stimulating or making useful any motivation that the individual might possibly have if they were taken in hand early.

Specific things that occur to me also, and then I have finished, are these:

There should be, I think, some consideration in encouraging, and I do not know just how it would be done, the availability of some of the things that would make it easier for these people to face the future.

On a simple thing like health insurance, the individual who is disabled, whether they have mental disability, physical disability, very often is denied the opportunity to buy health insurance.

The fear of illness, the hazard of some illness that may have nothing to do with the person's disability, is anxiety, provoking and interferes with the proper adjustment; these people are fearful so far as their families are concerned.

They are fearful so far as taking advantage of opportunities is concerned, because they feel that if anything should happen to them they have nothing to fall back on except some public source, which is depressing.

There should be, I think, some recognition of the fact that we have an increasing number of chronically ill people. They are growing not only in terms of percentage, but as the population grows in terms of numbers.

A tremendous amount of education is necessary so that people will accept, by and large, the fact that there are many conditions in which control rather than cure is the aid.

I think I am probably coming back and saying another way that efforts in the field of rehabilitation have to encompass education of the public certainly, but more particularly those who are in close proximity to the individual.

Finally, comes the question of employment. There is a tremendous enthusiasm in an academic way about employing people who are disabled, either physically or mentally, but the figures are really a little depressing.

People who are in good health, presumably, don't get employed too well after the age of 48, unless they have some special art or craft. I have forgotten the exact figures, but I remember once asking the director of the employment office in Birmingham how many people had been hired in 6 months who were over the age of 50, and it was a startlingly small number.

The ones that had been hired were people who had a special skill and there was some demand for their services.

So the problem of employment is a terribly important one in a practical way, and I believe that any rehabilitation efforts should encompass the development of individuals who do little more than study the industries in the areas and find jobs so that the employers can be sold on the job being done rather than the man.

If the man is sent out and he has all the recommendations that he needs, that he can be an upholsterer or do any one of a number of things, he may or may not find employment.

But if jobs can be identified and then men trained to do them, and then the employers sold on the feasibility, I think we would employ more. I think it would become a more realistic concept to the employer if they could be shown, that it was not his good will that we wanted, or it was not his desire to be an aid to this community effort, but that he could profit from the effort of this man in this job in the way that he profits from the efforts of his other employees.

I think we would do better.

I want to thank you for listening.

Mr. ELLIOTT. Thank you, Dr. Weil. You have stimulated my thinking very much, and I appreciate it.

We are glad to have you. What type of practice do you have, Doctor?

Dr. WEIL. I am an internist, and I came down here from 2 years in an occupation medical clinic in Boston, Mass.

It is about the only one, though, there may be several others. There are many industrial health clinics, but Dr. Harriett Harding, who is the director of this one, called hers the occupational medical clinic for

the reason that we were just as interested in the housemaid's knee as someone with silicosis.

It gives you a broader approach.

Mr. ELLIOTT. I hope you find your stay here rewarding, and I hope you will feel free to give us the benefit of your thoughts.

Dr. WEIL. I have been here for 5 years, so I guess I am an oldtimer now.

Thank you.

Mr. ELLIOTT. This completes our list of witnesses for today.

Let me again express to every person who has made these hearings possible my very deep feeling of pleasure. I expressly appreciate the citizenship of Cullman and Cullman County, to the public officials who have done so much to make this stay of our subcommittee pleasant and rewarding.

I publicly thank the members of my staff and of the staff of the subcommittee for making the arrangements which have enabled us to hear 60 witnesses in 2 days. Out of this I hope will grow something that we can all feel proud of.

I notice Mr. Jim D. Moody, chairman of the governing body of Cullman County, Ala., is in the courtroom. We appreciate his encouragement of these hearings.

The subcommittee will stand adjourned.

(The following statements and letters were submitted :)

STATEMENT OF HON. CHARLES E. BENNETT, A REPRESENTATIVE IN CONGRESS FROM
THE STATE OF FLORIDA

Mr. Chairman, I appreciate your giving me this opportunity to appear before your committee today in behalf of my bill, H.R. 7546. My bill would amend the Vocational Rehabilitation Act in order to provide assistance to the States for certain workshops, rehabilitation facilities, and rehabilitation evaluation services. It would authorize appropriations beginning at \$10 million the first year and rising to \$15 million during the third and subsequent years for the purpose of encouraging and assisting in the establishment of public and other nonprofit workshops and rehabilitation facilities needed in rehabilitating physically and mentally handicapped individuals. It would also authorize appropriations for rehabilitation evaluation services.

In introducing this bill, I have been cooperating with the Goodwill Industries of Florida. Recently, Mr. Robert C. Adair, executive director of this organization, wrote me an excellent letter regarding the need for enactment of this bill. I would like to quote from his letter, since it is the best statement I have seen on the bill:

"Better than 1 out of every 10 persons in the United States have a serious physical, mental, or social handicap. These are very conservative figures, as I believe the last figures issued by the Department of Health, Education, and Welfare Office of Vocational Rehabilitation, had upped this to 14 percent of the total population. You can see what a drain we would have on our welfare funds if all these handicapped people were not given a chance to work and earn, and had to be supported by the Government.

"The waste in productive labor market would also be tremendous, but the greatest tragedy of all would be the blighted personalities and the unhappy lives of this great section of our population.

"Happily, however, handicapped people do not sit down and allow someone else to solve their problems. For, approximately 9 out of every 10 handicapped people, either through family, friends or their own ingenuity, find the solution to their problem, but this still leaves from 1 percent to 1½ percent of our population that is handicapped and will be on relief the rest of their lives unless some rehabilitation organization helps them to make the best possible use of that portion of their body that is left, has them trained so they can perform a job, sees that they have such a job, and helps them to adjust socially and re-

ligiously to their community and surroundings so they can live the full, happy, abundant life that we all desire to live. * * *

"There is a tremendous shortage of well-managed and properly operated workshops. Grants for this type of service are greatly needed for the evaluation, adjustment, trade training, and terminal aspects of sheltered work.

"Thus you see, our goal of 1,000 handicapped people employed in Goodwill Industries by 1965, is not at all impossible if funds are available to us for the opening, the proper equipping and handling of these sheltered workshops.

"When you consider the potential of help that can be given to handicapped people in all 50 of the States, you can see the tremendous job that is ahead of the sheltered workshop.

"These goals are going to be achieved. These handicapped people are going to be given evaluation, adjustment, training, and work. The question is, when? If we have to raise all of our own money, our program will be slow, but will be certain, and we will reach our goals, but it will be in some time in the quite distant future.

"With help in the form of grants to sheltered workshops, we can reach these goals in the foreseeable future and the handicapped people can live and work now rather than planning for the handicapped people of the next generation.

"Sheltered workshops are like handicapped people—they do not ask for charity—they ask for a chance, and sheltered workshops simply do not ask for outright Government grants, but ask for matching grants, so we will do everything with our own power to carry on our own job, and then in relationship to the way we do this job the Government can help in proportion through matching grants.

"The suggestion in your bill of two Government dollars for every dollar that we raise and put into the program is a fine encouragement and will help to spur each of us who are in the sheltered workshop field to do our very best.

"If the \$1,800,000 that our handicapped employees pay in income taxes and social security could be made available to us in the form of expansion grants, our program would go ahead by leaps and bounds. We, of course, do not expect this money to be turned back to us because handicapped people are proud of their ability to pay income tax and to be a part of the great social security program. But if a grant of similar sum could be available, we would increase the amount of these taxes coming into the Federal Government many-fold.

"We feel it is just good business to take handicapped people out of the relief line where they are tax users and put them in the payroll where they become taxpayers. But greatest of all, we feel that it is our God-given commission to help every handicapped person possible to live the fullest, the happiest and the most abundant life of which he is capable."

I will deeply appreciate your committee's careful and serious consideration of this bill. I hope it will be possible to report it favorably.

STATEMENT BY DR. A. P. JARRELL, STATE DIRECTOR OF VOCATIONAL REHABILITATION, STATE DEPARTMENT OF EDUCATION, ATLANTA, GA.

Mr. Chairman and members of the subcommittee, it is a high privilege to appear before this distinguished committee on behalf of disabled people who need help in achieving economic and social independence.

At the outset, I want to say that the vocational rehabilitation forces in Georgia endorse the provisions of the pending bill to expand the services now provided under the joint Federal-State program, namely, H.R. 3465. We also endorse House Joint Resolution 494.

The Georgia Rehabilitation Association, representing nearly 1,000 professional workers and lay people, recently passed a resolution supporting the provisions of H.R. 3465. A letter reporting this action was sent to the chairman of your committee.

As to the need for such legislation, may I outline briefly the situation in my State.

During the past 5 years, 26,117 disabled civilians have been restored to productive jobs through the services of the joint Federal-State program of vocational rehabilitation. There has been steady increase, year by year, in the number of rehabilitations for the past 10 years.

Throughout a 5-year period, we have provided services to nearly 12,000 disabled persons annually. At the end of the fiscal year 1958-59, there were

5,938 cases on the active rolls still receiving services, and there were 8,450 applications for services awaiting investigations. Moreover, there are thousands of other seriously disabled people who need services which we are unable to provide because of the lack of funds, facilities, and trained personnel, and because of legal restrictions.

The Office of Vocational Rehabilitation estimates that there are in the Nation about 2 million disabled persons who need vocational rehabilitation services, and 250,000 annually are becoming disabled. On this basis, it is estimated that there are about 30,000 disabled people in need of vocational rehabilitation services in Georgia.

Under the "support program" Georgia received \$2,222,889 of Federal funds during fiscal 1959. The State spent \$1,450,016.87 for this program, which was \$219,164.87 more than the amount required to match Federal funds. This year, 1959-60, we have nearly \$300,000 of State funds in excess of the amount required to match the Federal funds.

As pointed out in my letter of June 22, 1959, to the chairman of this subcommittee, Georgia appropriates, on a per capita basis, more funds for vocational rehabilitation services than any other State in the Nation.

There are several other States which are appropriating more funds than OVR can match under the present formula.

Therefore, Mr. Chairman, we respectfully urge that the allotment base be increased at least in an amount sufficient to give these States enough Federal funds to match the State funds available. From my study of the formula for distribution of funds for the "support program," an allotment base of approximately \$85 million would be required. This would enable these States to expand their programs in vital fields.

We are hopeful that Congress will see fit to amend section 3 of Public Law 565 so as to permit the transfer of extension and improvement grants from those States which are unable to use them to States which have sufficient funds to activate projects under this section. This proposed change in the law would be helpful to the States which are financing adequately their part of the program.

Georgia is undertaking a tremendous expansion of its mental health program. It involves an expansion of facilities, staff, and services at the Milledgeville State Hospital; a new hospital for the mentally ill in Atlanta, together with five additional intensive treatment centers similar to the one now in operation at the Talmadge Memorial Hospital and Medical School at Augusta. The cost is estimated at \$15 million above what is now being spent for the treatment of the mentally ill.

The Georgia Rehabilitation Agency is cooperating with the State Department of Public Health and the State Department of Public Welfare, hospitals, and other agencies, in developing a coordinated rehabilitation program for mentally ill, emotionally disturbed and mentally retarded persons.

Our counselors work with teams of specialists at several hospitals in planning rehabilitation services for mental patients and epileptics who ultimately may be returned to employment. As the mental health program expands, additional counselors will be needed for this specialized service.

For the fiscal year 1958-59, the agency rehabilitated only 137 mentally ill persons. Currently, we are providing rehabilitation services to about 400 individuals whose disability has been diagnosed as emotionally disturbed.

The mental health program has the backing of the Governor, the legislature, and citizens, generally. It will offer a great opportunity—and challenge—to the rehabilitation agency to provide rehabilitation services to patients from these hospitals and centers. But more money will be required. If more funds were available, I am confident we could increase the number of rehabilitations among persons with mental handicaps threefold in the next 2 years.

I am of the opinion H.R. 3465 represents a logical and constructive step in the development of the Nation's rehabilitation services. Year after year, we are compelled to decline services to thousands of applicants who do not have the rehabilitation potential to qualify under the present law. Many of these people, we are certain, could be restored to some degree of self-sufficiency as envisioned under H.R. 3465—the "independent living" rehabilitation measure.

As evidence of Georgia's interest in "independent living rehabilitation," the general assembly, at its 1959 session, amended the State rehabilitation laws to authorize this type of service. We are planning to put this measure in effect

when appropriate Federal legislation is passed and Federal funds become available.

In Georgia, there is a pressing need for more workshops and vocationally oriented rehabilitation facilities to serve more of the mentally ill, epileptics, mentally retarded, blind, deaf, cerebral palsied, and other seriously disabled individuals. There is a great need especially for work evaluation and diagnostic units within both rehabilitation facilities and sheltered workshops. With such facilities, we could rehabilitate many borderline cases which now are neither ready for vocational schools nor competitive employment. This situation is another reason for our strong endorsement of H.R. 3465.

In Georgia, the school for the deaf is a unit of the vocational rehabilitation division. We know from long experience that it is difficult—if not impossible—to get specially trained teachers of the deaf to staff this school. During the past 10 years enrollment there has increased from 291 to 427, which shows the increasing need of well-qualified teachers.

Of scarcely less importance is the pressing, urgent need for psychologists, social workers, counselors, and speech therapists. The ability of these professional workers to serve the deaf is seriously limited because of lack of special training necessary for evaluating and meeting their needs.

We know, too, that there is a shortage of trained audiologists and speech pathologists in the private agencies from which we purchase services for our clients. Frequently our clients with hearing and speech impediments are compelled to wait for weeks before appointments at these centers can be met.

Enactment of House Joint Resolution 494 would in time help materially in remedying this shortage of trained personnel in these fields.

We shall be glad to have any members of this subcommittee—or your colleagues in Congress—visit Georgia and observe the operation of our vocational rehabilitation program.

I thank you, gentlemen, for the opportunity to appear here today. If there are any questions, I shall be glad to undertake to answer them.

THE BIRMINGHAM INSTITUTE OF
PHYSICAL MEDICINE AND REHABILITATION,
Birmingham, Ala., February 1, 1960.

HON. CARL ELLIOTT,
*Representative, Seventh District of Alabama,
House Office Building, Washington, D.C.*

DEAR SIR: As a specialist in physical medicine and rehabilitation I greatly enjoyed reading about your committee's procedure held in Cullman. The meeting was very timely and will be a great benefit to the citizens of our State. It seems to me that Alabama has just as good facilities and personnel as any other State but, probably, we are not utilizing the existing specialty and its ancillary forces.

Chronic illnesses, geriatrics, psychiatric cases, and the chronic alcoholics need more than rehabilitation per se. A chronic alcoholic may recover from its habit but quite often he has peripheral nerve involvement and incoordination of the muscles therefore before a job placement could be assigned to him he needs treatments and evaluation. Homes for the aged where our senior citizens are sheltered and boarded are in dire need of physical therapy and occupational therapy. These citizens could help out industry within their physical capacity and thereby could maintain their American way of life, economic independence.

May I offer the following suggestion to your committee:

(1) Utilizing all existing facilities whereby a team of physicians including a physiatrist, orthopedics, pediatrician, psychiatrist, internist, and surgeon could evaluate the best program for the future objective of the patient.

(2) Construction of a rehabilitation center at our new medical center where patient could receive dynamic physical medicine treatments as advocated by Dr. Howard Rusk of New York.

(3) Physical therapists, occupational therapists, and corrective therapists should be utilized to the fullest extent under the direction of a physiatrist since physical medicine and rehabilitation embrace those ancillary specialties.

(4) Establishing a school of physical therapy and occupational therapy where the young men and women of Alabama could receive training and thereby help our citizens.

Dear Mr. Elliott, call on me whenever it is convenient for you and may I offer my services to you and to your committee for utilizing all the services in the rehabilitation of the citizens of our great State of Alabama.

Sincerely yours,

F. F. SCHWARTZ, M.D.,

Associate Professor of Physical Medicine and Rehabilitation.

COMMENTS OF CHARLES P. SCHUCH, DIRECTOR, THE WAKE COUNTY CEREBRAL PALSY CENTER, RALEIGH, N.C.

1. INDEPENDENT LIVING BILL

May I especially urge you to pass a form of legislation which empowers the local unit of the department of vocational rehabilitation to authorize expenditures to provide necessary medical evaluations, speech therapy, physical therapy, occupational therapy and other forms of rehabilitation training which will enable a handicapped person to become physically independent even to enable him to become economically so. I personally have seen many cases such as the housewife that could manage her home independently as a result of such training but was unable to get vocational rehabilitation assistance because there was no likelihood of her getting a job. This situation is true of many stroke victims who could relieve another member of the household if given the proper training. I sincerely and firmly believe that the value of the Office of Vocational Rehabilitation in our society would be greatly increased if given the opportunity to permit independent living.

2. SPEECH PATHOLOGY

Although there is a great need for an increased number of speech pathologists in the southern region, I personally feel there is even a greater need for qualified speech therapists (with somewhat less training than a speech pathologist). There are major medical centers throughout the South which do have the services of a speech pathologist available for consultant activities to aid local rehabilitation centers which attempt to provide speech therapy. However, there are a great many local facilities such as our own which are handicapped by the very acute shortage of adequately trained speech therapists. I feel that one reason for this acute shortage in the South is because there are so few accredited speech therapy training schools in our area. As a result, many native southerners immigrate to the North and West for this training and upon graduation are lured into employment by a local facility in that area. I personally feel that it would be money well spent if the Department of Health, Education, and Welfare could provide money to help establish adequate programs to train speech therapists in southern colleges and universities.

3. CRITICAL SHORTAGE OF OTHER ANCILLARY MEDICAL PERSONNEL

In addition to the critical shortage of speech therapists in the South, there is also a very acute shortage of physical therapists and occupational therapists. I speak from personal experience when I say that in North Carolina along there are presently enough vacancies to increase the number of physical therapists in the State by at least 25 percent. It has been only in the past 3 years that new schools have been established to train physical therapists, at the University of North Carolina and the University of Florida. I feel sure that in the near future the graduates from those new schools will help to relieve the shortage of physical therapists, but even the most optimistic person would not expect these schools to completely relieve the shortage. In line with the things included above concerning new facilities for training speech therapists, I feel that it would be money well spent to help establish one or two more schools of physical therapy in the southern region. The situation in occupational therapy is very much the same. The demand for personnel has been continually increasing in the past 10 years at a rate greater than the schools are able to train them.

UNIVERSITY OF SOUTH CAROLINA,
Columbia, January 22, 1960.

HOB. CARL ELLIOTT,
*Chairman, Subcommittee on Special Education,
Committee on Education and Labor,
House of Representatives, Washington, D.C.*

DEAR REPRESENTATIVE ELLIOTT: I appreciate your kind invitation to appear before your committee during the public hearings in Cullman, Ala., January 27 and 28. Unfortunately, I shall be unable to attend these important discussions.

In my opinion, the basic problems faced in South Carolina with regard to the field of special education are:

1. The fact that persons with adequate preparation and experience to serve on faculties of colleges and universities offering teacher preparation in special education simply do not exist in this State. In fact, they are so few throughout the United States that institutions are not able to train teachers as they must be trained. In some way, we must increase the number of competent teachers of special education.

2. State requirements for licenses or certificates to teach handicapped children are vague and, at times, not enforced because the supply of teachers is so limited. I believe this situation will improve when the supply of college instructors is increased.

Sincerely yours,

WILLIAM W. SAVAGE,
Dean, School of Education.

STATEMENT BY C. ROBERT GRAVES

Mr. Elliott and members of the committee, I am Bob Graves of Lakeland, Fla., currently associated with Radio & Television Transcript Service of New York as their central Florida field representative. I am president of the Polk Federation of the Blind, a member of the board of directors of the Florida Federation of the Blind, and editor of the Florida White Cane. I come to you as the representative of the organized blind of the State of Florida and as such am the only authorized representative of any of the blind of that State who has been chosen by the blind themselves.

Insofar as it is possible I shall attempt to avoid giving testimony that has already been presented to you orally. In general the Florida Federation of the Blind fully approves and wholeheartedly supports the recommendations made by the Atlanta workshop. We are, of course, very much interested in supporting and urging a number of proposals that were not considered by the Atlanta workshop. I shall, however, attempt to restrict my testimony to matters that were covered in Atlanta.

During the hearing, Congressman Green asked a number of questions that lead to the line of discussion. Are special services and agencies for the blind really necessary? We believe that the answer in both instances is "Yes." I feel that this was also the conclusion of the Atlanta workshop. The workshop recommended a number of special services for the blind that were not recommended for any other category. It specifically recommended that the Federal Government encourage States providing services for the blind to establish special agencies to administer these programs and that where these services were being provided by a general agency that they be administered by a special division within that agency.

To be sure blindness is a handicap in many ways and is therefore a disability. We believe, however, that the severity of this disability is far greater than its actual physical limitations because of the many misconceptions held concerning it. Entering the world of the blind those who lose their sight bring their misconceptions with them. Those who serve the blind must therefore counteract not only misconceptions held by the general public but the same misconceptions as held by the blind themselves. Unfortunately these workers unless they are specially trained or experienced are also subject to these misconceptions. It is practically impossible to avoid this situation where workers or administrators must concern themselves with more than one program of services.

Laws enacted and departmental rules and regulations already written have recognized in many ways that the physical limitations of and the misconceptions concerning blindness give rise to special needs and services and special approaches for the blind client. Here in Florida we have a special agency that administers rehabilitation services for the blind and handles their needs in some other areas but the program of blind assistance is administered by the welfare department without any separation of the blind from other categories. When the Federation went before the committees of the State legislature to discuss this program we found that all of the thinking and planning of the welfare department was based on the old-age assistance program. The objection to establishing a special division for the blind is that the blind are only a small minority and that their numbers do not justify such special considerations.

We believe that it has been established that the blind have some special needs and that these needs will not be met unless they are given special consideration and we further believe that any group no matter how small are entitled to all of the services to meet their needs. It is further argued by some that if we are to give such special consideration to one handicap that the other handicapped can equally argue with justice that they too should be given the same special consideration. We do not believe that it has been established that these other groups of handicapped persons have such specialized needs as do the blind.

It has been argued in some quarters that agencies for the blind should also serve the group known as the partially sighted. For services of this nature blindness has generally been defined as a visual acuity of 20/200, etc. Therefore among the blind there are those who have no vision and those who have some vision but an acuity of less than 20/200. There is a far larger group that have some visual defect but whose acuity is greater than 20/200 and less than 20/70. This group is now eligible for service by the general rehabilitation program because they do have some handicap in some areas. Because of the comparative size of this group and because of the facility with which its problems are solved we believe that their inclusion in services for the blind would result in a very material loss of services to the blind. The general rehabilitation program already has the authority to serve this group and we do not believe that they require a specialized personnel for administration and therefore we oppose any change in their status.

We fully support the provisions of H.R. 3465, the independent living bill. We think that the services it proposes are badly needed and that the bill should be enacted. We would like to see the bill amended in respect to the blind, removing its services from the field of rehabilitation and placing them in the field of medical and social services. We believe that a rehabilitation to any extent feasible should be accomplished when and wherever possible but we do not believe that agencies should be permitted to deceive us by reporting that a client is fully rehabilitated when this has only been partially accomplished. We deceive no one but ourselves if we rehabilitate persons by securing for them partial self-support and force them to remain on public assistance to secure the remainder of their support. They have neither been rehabilitated or removed from the welfare rolls. If this bill cannot be amended in this fashion then Public Law 565 should be amended so as to require rehabilitation agencies to report their closures in such a detailed manner as to make it obvious as to which cases have been rehabilitated with total self-support and which with only partial self-support.

The Atlanta workshop, because of the time limitation, did not discuss the subject of disability insurance but from private conversations I feel sure that there would have been a consensus of opinion in support of our recommendations if that part of the agenda had been reached. We recommend the elimination of the minimum age of 50 where the disability is blindness. We feel that where an individual suffers from this disability that his loss is just as severe at the age of 20 as it is at the age of 50. We recommend the elimination of the requirement that the disability of blindness occur after the applicant has met the requirement of employment in a covered industry. We feel that the disability of blindness is just as severe whether the applicant became blind before or after he was employed in a covered industry. We recommend the reduction of the requirement of employment in a covered industry from 20 quarters to 1 quarter for blind applicants. A large segment of the blind population is past the age of productive employment at the onset of their disability and would qualify for benefits under other provisions and only a small percentage of those in the employable age group are employed in covered industry. We feel that it should

be made as easy as possible for these persons to qualify for benefits so as to prevent the necessity of their placement upon the welfare rolls. We feel that referral to rehabilitation should be recommended but not mandatory. There are instances in which rehabilitation is feasible but because of personal and family relations is not desirable.

We would like to see the reduction or elimination of the severity of State residence requirements, participation by the Federal Government in the home teaching program, a larger and more adequate library program for the blind and other improvements in services available to the blind. This committee has already held extensive hearings in regard to the violation of the civil rights of the blind but we would again like to remind you of our support for this legislation.

It is our sincere hope that these thoughts have been of help to you in formulating legislation and that you will feel free to call upon us if we may be of further assistance to you. We thank you for the opportunity to express these views.

(Thereupon, at 5 p.m., the subcommittee was recessed, to reconvene subject to call of the Chair.)

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1874

SPECIAL EDUCATION AND REHABILITATION

HEARINGS
BEFORE THE
SUBCOMMITTEE ON SPECIAL EDUCATION
OF THE
COMMITTEE ON EDUCATION AND LABOR
HOUSE OF REPRESENTATIVES
EIGHTY-SIXTH CONGRESS
SECOND SESSION
ON
H.R. 1119, H.R. 3465, H.J. Res. 488, H.J. Res. 494
BILLS REGARDING THE FIELD OF SPECIAL
EDUCATION AND REHABILITATION

PART 4

HEARINGS HELD IN JERSEY CITY, N.J.
FEBRUARY 18 AND 19, 1960

Printed for the use of the Committee on Education and Labor



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SPECIAL EDUCATION AND REHABILITATION

THURSDAY, FEBRUARY 18, 1960

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON SPECIAL EDUCATION
OF THE COMMITTEE ON EDUCATION AND LABOR,
Jersey City, N.J.

The subcommittee met at 10 a.m., pursuant to notice, in Freeholders Assembly Chamber, Hudson County Administration Building, Hon. Carl Elliott (chairman of the subcommittee) presiding.

Present: Representatives Elliott (chairman of the subcommittee), Daniels, Giaimo, and Quie.

Also present: Dr. Harry V. Barnard, clerk of the subcommittee.

Mr. ELLIOTT. Ladies and gentlemen, I welcome you to the hearings of our Subcommittee on Special Education of the Committee on Education and Labor of the U.S. House of Representatives.

This subcommittee is meeting here in Jersey City to receive testimony from the public on the most unmet needs of the Eastern Atlantic States in the fields of special education and rehabilitation. We are seeking, I might say, specific suggestions as to how the Federal Government may best aid the States and local communities in finding a solution of some of the problems in these fields.

These hearings are part of a comprehensive study our subcommittee is making of the areas of special education and rehabilitation.

We are reviewing legislation, analyzing Federal and State services in all the areas involved, and trying to determine what services are now available and what services are actually needed.

The hearings grew out of a real need on the part of your U.S. Congress, to reassess this whole area of special education and rehabilitation.

Early in the 1st session of the present 86th Congress a flood of bills dealing with special education, specifically with the physically handicapped, were introduced.

At the present time over 110 bills pertaining to this area are pending before our subcommittee.

Rather than legislating haphazardly or rushing into ineffective legislation, we decided to make an exhaustive study of the entire field to learn the unmet needs and how we could best cooperate with the States and local communities in solving them.

This is the fourth in our series of hearings. We have previously held similar hearings in New York City; New Haven, Conn., and Cullman, Ala.

Further hearings are scheduled for Portland, Oreg., Los Angeles, Calif., and Chicago, Ill.

Our stay here in Jersey City, I may say, has thus far been a most pleasant one.

Sheriff Flannagan has been more than hospitable to us. You know, I am well on my way to believing all of the wonderful things your fine Congressman, Judge Daniels, has been telling me about this city.

Let me tell you, though, that Texans have nothing over you people from Jersey City. Judge Daniels tells such marvelous stories about this fine city that even the Texans have been taking notes from him to use in their own chamber of commerce brochures.

This assembly chamber is very beautiful. This is just one of the many things you have to be proud of and for letting us use this beautiful chamber, I would like to thank the Board of Freeholders of Hudson County.

At this time I recognize your Congressman, Judge Daniels, to present Mr. Gangemi, your county supervisor of Hudson County, N.J.

Mr. Daniels.

Mr. DANIELS. Mr. Chairman, Congressman Giaimo, Congressman Quie, and ladies and gentlemen, I feel very, very happy that these hearings are being held in the 14th Congressional District of the State of New Jersey, the district which I have the privilege of representing.

I welcome the subcommittee here.

I would like to introduce at this time our county supervisor, the congenial and affable Tom Gangemi.

In order that you may understand what a supervisor is, I would like to explain his function to my colleagues and to those people in the audience who come from areas where you do not have a supervisor. I would like to say that his position is more or less akin to that of county mayor.

Our county government is in the hands of a board of freeholders consisting of nine members who are in charge of all of our county institutions. I wish this committee will have the opportunity and I do trust the county supervisor will extend to the committee, if time will permit, an opportunity to visit the county institutions which are in charge of our board of freeholders and the county supervisor.

I am very, very proud of the institutions that we have here. We have not only a large county mental disease hospital, but also a geriatrics hospital, a hospital for our tuberculosis patients which recently embarked upon an entirely new area of operation—that of cardiac cancer surgery. Besides that, we have a maternity hospital and a number of other services which the community as a whole is sorely in need of.

I would like to call upon our county supervisor, Thomas Gangemi, to present a message of welcome.

STATEMENT OF THOMAS GANGEMI, COUNTY SUPERVISOR, HUDSON COUNTY, N.J.

Mr. GANGEMI. Thank you, Congressman Daniels.

Chairman Elliott, fellow Congressmen, ladies and gentlemen, as county supervisor I want to welcome this Committee on Education and Rehabilitation. I feel that this committee has done a wonderful job and are doing a good job because we in Hudson County realize that this program will more or less affect us not only in Hudson County, but throughout the State.

We realize that in our institutions we have a mental hospital where our patients are mentally disturbed or emotionally disturbed and because of the importance of this hearing and this bill that they are trying to set forth, we feel that not only us in Hudson County will be benefited by this great bill, but also throughout the country.

I want to welcome you here, Mr. Chairman, with the honorable Congressmen who are on this great committee, and I want to assure you that we in Hudson County not only welcome you, but invite you to visit our institutions and every other public office within the county and I can assure you that this stay here with your committee will be a pleasant one because we in Hudson County will make it pleasant for you.

I want to congratulate you and the rest of your committee for the fine job that you are doing.

I wish you at this time good luck and God bless you all.

Mr. ELLIOTT. Thank you very much.

The visiting members of our subcommittee are very happy to hear those fine words of welcome by Mr. Thomas Gangemi, county supervisor.

On my right, as those present know, is Mr. Dominick V. Daniels, Representative in Congress from this 14th Congressional District of New Jersey.

Mr. Daniels has served all his time since he came to Congress as a member of this subcommittee and of the full Committee on Education and Labor.

On his right is Congressman Bob Giaimo, a Member of Congress from the State of Connecticut. His district is New Haven, and its environs.

Mr. Giaimo, likewise, has served his entire stay in Congress on our committee.

The interest, I might say, of Mr. Daniels and Mr. Giaimo has been a source of considerable inspiration and encouragement to the committee.

On my left I have the pleasure of presenting Mr. Albert Quie. Congressman Quie is serving his first full term in the Congress of the United States, from the State of Minnesota, and he has likewise been assigned to the Committee on Education and Labor and has demonstrated his deep interest in the questions pertaining to education, special education, labor legislation, with which our committee deals day in and day out.

I have just received a telegram from Mrs. Florence P. Dwyer, a Member of Congress from the State of New Jersey. This telegram is addressed to me. She says this:

Deeply regret commitments in Washington make it impossible to accept your thoughtful invitation to participate in your important hearings.

I congratulate you and your subcommittee, including my distinguished New Jersey colleague, Congressman Daniels, for actively seeking, through public hearings in the field, the ideas of those who work for the betterment of our people. I plan to submit a detailed statement of my views on pending legislation.

Meanwhile, may I ask that you include this telegram in the public record as testimony of my strongest support for H.R. 3465 and House Joint Resolution 494. Growing incidence of chronic disability and increasing population of the aging make it imperative that noninstitutional means be found to restore disabled to independent living.

Also, as a member of board of trustees of Gallaudet College for Deaf, I know firsthand how urgent is the need for more well trained teachers of the deaf and for trained speech pathologists and audiologists.

In the midst of American plenty, we owe greater care and attention to the needs of our handicapped and disabled people.

FLORENCE P. DWYER,
Member of Congress.

Mr. ELLIOTT. Our first formal witness today is the Honorable Raymond F. Male, the State commissioner of labor of the State of New Jersey, and chairman of the State rehabilitation commission of Trenton, N.J.

Mr. Male, we are very happy to have you and we look forward to your testimony. You may proceed at this time.

Now, 30 witnesses, or thereabouts, have indicated their desire to testify today. That being true, it will be necessary that our individual testimony be restricted in time as much as possible. I hate to put a very minute time limitation on it, but maybe a little later today we will have to do that.

But let it be said that if the witnesses will summarize their statements orally and submit their written statements for the record, that the written statements will be made a part of our official record immediately following the oral statement.

We have found in the past that by handling it in that manner we are able to save some time.

We, likewise, have about 35 witnesses scheduled for tomorrow.

Now, with that as a background may I ask you, Mr. Male, to proceed.

**STATEMENT OF RAYMOND F. MALE, STATE COMMISSIONER OF
LABOR, AND CHAIRMAN OF STATE REHABILITATION COMMISSION,
TRENTON, N.J.**

Mr. MALE. Thank you very much, Mr. Chairman.

First, let me say that I will heed your sound advice with respect to the time in this hearing. I think I can stay well within the 10 minutes suggested.

Secondly, I would like to say on behalf of Robert B. Meyner of New Jersey, that he would like very much to have been here to testify personally in support of the work of your committee and, in particular, in support of H.R. 3465.

The Governor is not in the State today, but he did ask me to express to you his greetings and to hope that your stay here will be both a pleasant one and a productive one.

The Governor did meet with our 14 Members of Congress from New Jersey and our 2 U.S. Senators within the last fortnight in Washington and on that occasion at a special breakfast which he holds annually with them in discussing legislation of particular interest to New Jersey endorsed H.R. 3465.

So it is clear on record in that connection.

New Jersey, I am sure you are well aware, has a long history in the field of rehabilitation. Not far from this very hearing room we have the world famous Kessler Institution of Rehabilitation.

Even more importantly the world famous Dr. Henry Kessler, himself, who has breathed into New Jersey and into those of us who carry official responsibility for some phase of this work, the kind

of enthusiasm and fire and philosophy about this that I think you will find bubbling through many of the witnesses who will talk to you today and tomorrow, from officials, as well as from voluntary and private agencies in New Jersey who are concerned with this field.

In more recent years New Jersey, with, I must say, strong Federal participation, support and leadership, not only financially, but also staffwise from the Office of Vocational Rehabilitation and other agencies, has been helping us to increase the tempo of our effort in this field of rehabilitation and in the last few years actually our progress in this, our performance has doubled.

MR. ELLIOTT. Mr. Male, let me ask you right there, are the functions of vocational rehabilitation in your office?

MR. MALE. They are. I wear two hats. One as commissioner of labor and industry; the second as chairman of the rehabilitation commission.

I might point out that those who set up this commission back in 1918 had the wisdom to place in that commission also the responsible cabinet officers, dealing with the fields of education and of institutions and agencies which in New Jersey represent mental health, corrections and public welfare.

MR. ELLIOTT. What is your population of the State of New Jersey?

MR. MALE. The population is now approaching 6 million and we are told we will pass that figure in October of this year.

MR. ELLIOTT. How many people did you rehabilitate last year to employment or reemployment?

MR. MALE. Through the rehabilitation commission somewhat more than 1,300 which I hasten to add was only 1 in 6 of the non-need in New Jersey.

These, as you also know, were vocational rehabilitation. We are tremendously concerned in this State that because of the limitations of our law, as well as the Federal enactment there are many, many people for whom we cannot presently, with known knowledge, and known professional skill, anticipate productive employment at the end of rehabilitation.

That is why we are particularly interested in title II of your proposal with respect to independent living rehabilitation.

Personally, I spent some 7 years working in the department of institutions and agencies in New Jersey where we were responsible both for public assistance programs, the State mental health programs, the commission for the blind, and also the licensing of nursing homes in New Jersey.

I would like, therefore, to say on this point that I have seen firsthand the victims of the kind of neglect that I think this bill would go a long way toward meeting, toward fulfilling the need.

We have in our rehabilitation commission, as I mentioned, these many departments represented. I think one area not represented, but which should be, is our State health department, because our commissioner of health, Dr. Roscoe Campbell, who met with us yesterday on the subject of this bill, is very enthusiastic about the purpose and philosophy contained therein.

Also, on this commission are representatives of labor, of management, of the public at large, and of interested citizen groups.

We are not so concerned about the left hand and the right hand of our bureaucracy.

I am aware that throughout the country there are people in some fields of public administration who are concerned about where the responsibility should be placed for this important program.

Frankly speaking, as a commissioner of labor and industry, and as chairman of our rehabilitation commission, I could not care less where it is placed in our bureaucracy, but I could not care more about the fact that this should be done and I hope that your committee will bear that in mind.

I personally think that because of the philosophy and the feeling of the rehabilitation people in New Jersey and the tradition not only of citizen support, but the tradition of multiagency, public and private cooperation, that we can get off the ground rapidly if this legislation were to pass.

I would like to point out, too, one area that may not be touched upon by other witnesses from New Jersey, another area of close concern of mine because of my position as commissioner of labor and industry, and that is our responsibility for administering the workman's compensation program in New Jersey.

I would like to point out to the committee, if I may, that this program, too, has a close relationship to the field of rehabilitation and not just the field of vocational rehabilitation.

Our staff, our referees, our directors, find very often that the severely injured worker from industry may not have a vocational objective after all we can do under present methods, statute, knowledge, and so on.

We think that this provision for rehabilitation for independent living is going to reach hundreds of people in this State in that category.

We would like also to point out to you that New Jersey as the first of the 50 States has a demonstration grant of funds from the Department of Health, Education, and Welfare, through the Office of Vocational Rehabilitation and we have since July 1 of this past year been working to promote an office of coordinator between our workman's compensation program and our rehabilitation program.

This is already paying dividends. We are interested more frankly in the actual restoration of the disabled injured worker than we are in the mere financial recompense, however, important that may be for the disability or the injury, itself.

We hope, in line with the philosophy that has been New Jersey's over the years, to find these people instantly and to get them in the hands of people interested in rehabilitation and not to wait for the long months and years that frankly sometimes it takes lawyers to figure out what their rights are under State workman's compensation statutes.

I would like to say that we are interested in your bill and in the work of the committee in a broad way for another reason.

Witnesses, including the director of our rehabilitation commission and staff people from other agencies of the State, will speak specifically to you about details of the bill. Some may frankly differ with you on some aspects of it, but I would like in summary just to point out that we feel that this bill is more than just better living for the people who will be benefited by it. I personally think, and it is the feeling of the administration in New Jersey, that increasingly in

America and from America, comes the impression that we are a kind of materialistic people who may be more interested in how high the tail fins go on the new automobile than we are in some of these human values that have really been the strength of America over the years.

To the extent that you and your distinguished colleagues on this committee are establishing not merely a program of great personal benefit to people who need it most and for whom there has been too little spoken in the past, many of them finding their way into the custodial care and backwards of State mental hospitals, many finding themselves in perhaps adequately run, but certainly not rehabilitation oriented run homes in the State, we feel your attention to this will be more than just correction of that abuse and the correction of that neglect, but it will represent a symbol to all of us in New Jersey, in America, and, frankly, I might say around the world, that we still are human beings interested and human beings centered in our approach.

I hope I have stayed within my 10 minutes, Congressman, and I hope your stay in New Jersey is productive.

Mr. ELLIOTT. Thank you very much.

How many nursing homes do you have in New Jersey, Mr. Male?

Mr. MALE. There may be others who have the exact number. I believe nearly 200 that are licensed by the State.

Mr. ELLIOTT. How many people live in those nursing homes?

Mr. MALE. You will have a witness from the department of institution; may I yield to them on that.

Mr. ELLIOTT. Our next witness is Dr. Kathryn Dice, representing the Department of Public Instruction, of the State of Pennsylvania and representing the Governor of Pennsylvania.

Dr. Dice, we are happy to have you. If you will proceed in any manner you desire and hold your testimony within 10 minutes, we will appreciate it.

STATEMENT OF DR. KATHRYN DICE, FOR GOVERNOR OF PENNSYLVANIA AND DEPARTMENT OF PUBLIC INSTRUCTION OF PENNSYLVANIA

Dr. DICE. Mr. Chairman, members of the committee, guests and friends of this committee, it is a source of personal privilege and pleasure to represent before this committee the Honorable David Lawrence, Governor of the Commonwealth of Pennsylvania, and Dr. Charles H. Boehm, superintendent of public instruction for Pennsylvania, as well as to appear in my own personal capacity as director of the bureau of special services to pupils within the State department of public instruction.

Our Governor sends to the committee his personal greetings and his regrets for his inability to attend, and commends the committee on its effort to approach the problems of special education and rehabilitation from the base of a body of factual material gathered from those most familiar with these problems at the State and local level, and from the point of view of the public as well as private agencies rendering services to the handicapped.

The State superintendent of public instruction likewise sends his greetings and wishes to express to you his continuous interest in and concern for the handicapped and provision for their needs as reflected in the programs of public education.

We in the bureau of special services to pupils are also proud of this opportunity to share with you some data about the growth of special education services in Pennsylvania and to present to you the joint recommendations of our State government as well as those of our public school system.

In the Commonwealth of Pennsylvania the functions related to the handicapped are the responsibility, along with other matters, of three branches of our State government. Vocational rehabilitation services are a part of our department of labor and industry, and this group will be represented in subsequent testimony scheduled for tomorrow.

Institutional programs and mental services are the responsibilities of the department of welfare and, in the case of the delinquent and predelinquent child, the department of justice.

Both of these branches of the State government in Pennsylvania will file with the committee written statements of their inability to be present during the days of the hearings.

The day school programs for the handicapped are the primary responsibility of the department of public instruction and, since this is a source of personal interest to the Governor and since this is my own personal field of interest, I will restrict my testimony to this phase, hoping that my colleagues from the State will pick up on the other types of services for the handicapped within our State.

I would like to point out to you that Pennsylvania is very proud of the legal basis for its special education services throughout the Commonwealth. Since 1953 we have had State-mandated special education on a statewide basis, based on broad enabling legislation which limits us only to the broadest terms mentally and physically handicapped.

For purposes of clarification, I would like to present to the committee as a part of an exhibit from Pennsylvania, and for inclusion in the record, a copy of our enabling legislation for class programs and a copy of a mandated transportation of the physically and mentally handicapped to education facilities, partly because we think this is a broadly permissive structure and because we were the first State in the Commonwealth to mandate simultaneously both educational and transportation facilities.

Mr. ELLIOTT. Without objection, the material to which the witness refers will be made a part of the record following her testimony.

Dr. DICE. I would also like to leave for reference purposes, if so desired, a copy of the school laws of Pennsylvania which will give additional services rendered through education to specific types of handicapped.

Next I would like to point out the impact of this legislation upon the State of Pennsylvania.

Working with a State-mandated program providing both education and legislation has, of course, had a tremendous impact upon the public school program. This has made possible the coordination of health, psychology, and educational services into a cohesive program for the handicapped which was no longer restricted to institutions

and sporadic programs, but could reach into every local district and even into the home of the child.

Under the impact of this legislation we have developed full-time class programs for children with severe disabilities, mainly in the physical and mental areas, itinerant services for children with sensory handicaps mainly in the areas of speech, hearing, and sight, home instruction for children unable to attend school, and clinical and diagnostic services in preparation for and for the continuance of education and rehabilitation services.

In this connection I would also like to submit for use in the record, if so desired, a progress report of the development of these services indicating what has happened in the State of Pennsylvania since State mandated legislation and indicating in the lower areas the services which we feel we would need in order to give full State coverage of educational services.

In connection with those, an actual breakdown of population served and a picture of a map showing the distribution of services through public education, our Governor is particularly proud of this because he feels that it represents a very wide layer of State coverage and services in this area.

Also, on the basis of such mandation public support of special education programs are of great importance.

For this purpose we would like also to submit for the record this small graph which indicates tax support for the programs of special education which have grown in a 6-year period from a \$4-million-plus grant in 1955, serving 63,000 children, to a \$21-million-plus grant in 1959, serving 122,000 children, and for consideration and study this material which relates to per pupil cost on the basis of the kind of handicap.

Finally, for the record, an overall summary of the public school enrollments in the State of Pennsylvania from which one can see that of our school population of 1,900,000-plus practically 120,000 children, or 6 percent, of our school population are at the present time enjoying some type of special education services, either on a full-time basis, on an itinerant service, or on a homebound instruction basis.

I would like to point out that this does not include the figures for institutionalized children which will be presented in subsequent testimony.

These special education needs, I think, point up also the needs in the vocational rehabilitation area.

For while public education through its special education has certain opportunities and privileges and services to offer to the handicapped, it is the role of the vocational rehabilitation to pick up in the areas of later use and adulthood.

We know in Pennsylvania that we have many unmet needs. I would like to name four of these very briefly, because this will mark out the role and the recommendations which we would like to present to you at the Federal level:

First, we need to know that we need to increase our full-time class programs by about 20 to 25 percent;

Secondly, we know that we need to increase our itinerant services to children suffering from speech, hearing, and sight handicaps.

Here we are at the mercy of reporting and casefinding methods which is the problem of coordination of the functions of our own State government.

But I would like to point out the need for 100 additional speech therapists, 150 teachers for blind and partially sighted children, and 167 teachers for the deaf and hard of hearing.

Third, we in Pennsylvania as yet have no organized pattern of services for the socially and emotionally disturbed and we estimate our needs at 40 diagnostic teams and a minimum of 100 class facilities.

Fourth, we have no reimbursed program for the gifted. We know that these are a State responsibility to a large degree, but we feel these could and should be shared and, therefore, our present unmet needs are the basis for the following 12 recommendations before this committee.

1. We in Pennsylvania feel that Federal consideration should be given to support for teacher education programs, particularly in the areas of critical shortage.

The training of supervisors in the area of mental retardation is now available through Federal funds.

We believe this type of legislation should be extended to include classroom teachers and that this support should be given along two lines:

First, for basic certification in a special field, either educational or vocational, as related to services to the handicapped;

Second, for others who with further training may wish to enter or reenter teaching in one of the areas of handicapped.

We firmly believe that this extra training and this aid for teacher education should be directed to college and university programs solely and for this reason wish to go on record as opposing House bill 494.

2. Second, consideration should be given to Federal support for the extension of vocational rehabilitation services.

In this connection we wish to voice our support of House bill 3465, and to suggest that consideration be given to the extension of vocational rehabilitation to the nonhandicapped, particularly adults who have never realized their potential who are ungraded vocationally and who have been deprived of or failed to take advantage of proper educational facilities.

This would be a true source of extending manpower and upgrading in a vocational and in a habilitation as well as rehabilitation sense.

In this connection also we want to solicit consideration of the term "employability," to broaden it and to extend it into other areas.

We wish to recommend Federal consideration to research and study through additional pilot programs, particularly in relationship to services for the socially and emotionally disturbed children and youth.

4. We wish to recommend Federal consideration for programs of the gifted.

Specifically in extending title V of the National Defense Education Act into the elementary level and lending support to a changing concept of the definition of the gifted to include a given percentage of the school population rather than a ceiling in terms of measured mental ability.

5. There is need for further consideration at the Federal level for the educational and rehabilitation programs as related to migrant labor and non-English-speaking groups.

6. There is need at the Federal level for research toward the evaluation of present existing programs and the effectiveness of what we are doing now.

7. There is need for direct financial aid for the establishment of regional libraries, curriculums and bodies of audiovisual aids, as well as demonstrating centers for teachers and counselors.

8. There is a need for publications from a general source for the use of the general public as well as for professional use.

9. Consideration should be given to financial aid for ancillary services for education and rehabilitation, particularly clinical and diagnostic.

10. There is need for coordination, for distribution, use and employment of services including aids and devices for all types of handicaps such as are now made available to the blind and deaf.

11. There is a need to consider in proposed legislation at the national level relating to school buildings and school building needs, the needs of handicapped children as well as the needs of the nonhandicapped.

12. There is a need at the national level, as well as at the State and local level, for the closer coordination between special education and vocational rehabilitation services to eliminate overlapping, to cover the gray areas and to consolidate services for the handicapped into a life plan with direct aid for experimentation through pilot programs of coordination of services at the State levels.

We from Pennsylvania are grateful for this opportunity and are grateful for noting the awakening of national interest in these areas.

Mr. ELLIOTT. Thank you very much, Dr. Dice.

May I say that the exhibits which Dr. Dice has offered will be made a part of the record immediately following her statement, without objection.

(The material referred to follows:)

WRITTEN STATEMENT BY L. KATHRYN DICE, COMMONWEALTH OF PENNSYLVANIA

Chairman Elliott, members of the committee, guests and friends of the committees, it is a source of personal privilege and pleasure to represent before this committee the Honorable David L. Lawrence, Governor of the Commonwealth of Pennsylvania, Dr. Charles H. Boehm, superintendent of the Department of Public Instruction for Pennsylvania as well as to appear in my personal capacity as director of special services for pupils of the State department of public instruction.

The Governor sends his personal greetings to this committee and to those assembled, regrets his inability to attend, and commends the committee on its efforts to approach the problems of special education and rehabilitation from the basis of a body of factual material gathered from those most familiar with these problems at the State and local levels, and from the point of view of the public as well as the private agency rendering service to the handicapped.

The State superintendent of public instruction, likewise, sends his greetings and wishes to express to you his continuous interest in and concern for the handicapped and provision for their needs as reflected through programs of public education.

We of the bureau of special services for pupils are also proud of this opportunity to share with you some data about the growth of special education services in Pennsylvania and to present to you the joint recommendations of our State government and our public school system.

In the Commonwealth of Pennsylvania the functions related to the handicapped are the responsibility, along with other matters, of three branches of our State government: (1) Vocation rehabilitation services are a segment of our State department of labor and industry; (2) institutional programs for mentally retarded children, mental health services and programs within correctional institutions are parts of the departments of welfare and justice; (3) day school programs for the handicapped and additional institutional programs for the blind, deaf and cerebral palsied are provided through the department of public instruction.

Through Mr. Charles H. Eby, director of the bureau of vocational rehabilitation, the nature and needs of this program will be presented in subsequent testimony.

Mrs. Ruth Grigg Horting, secretary of welfare will file with the committee for its consideration a written statement.

Since these two arms of State government are thus adequately represented I will confine my remarks to special education within the purview of the department of public instruction.

1. Legal basis for special education in the Commonwealth of Pennsylvania

Since 1955, by act of the legislature, Pennsylvania has had a statewide mandated public school program for mentally and physically handicapped children. In the same session of legislature, the provision of transportation for the handicapped to day school programs was also mandated. We believe in Pennsylvania that we are the first State to have simultaneous mandation of educational programs for the handicapped and transportation to these facilities. This type of legislation is an important indication of the interest of the general citizens and the legislature in the problems of its handicapped citizens.

For purposes of the record I am requesting that the following exhibits be included in the testimony of this witness and will leave with the secretary of the committee these exhibits; copies of act 429 of the General Assembly of Pennsylvania covering mandated programs of special education; act 673 of the General Assembly of Pennsylvania providing transportation for physically and mentally handicapped children; and copies of the School Code of Pennsylvania wherein are stated the additional provisions and extension of the services through public education to the handicapped.

2. Impact of this legislation

The impact of this legislation has been tremendous. For the first time it was possible within Pennsylvania to coordinate health, psychological, and educational services for the handicapped into a cohesive program so that special education could reach into every community and in some circumstances into the very home of the handicapped individual. Under this legislation, and dependent upon the nature and severity of the handicapping conditions, full-time class programs, programs of itinerant services, homebound instruction, residence programs, as well as clinical and diagnostic services have been made available. Suffice it to say in this oral testimony that as a result of this legislation services to the handicapped have tripled in size in the last 5 years.

To substantiate this statement and to present a comprehensive view of special education within the Commonwealth of Pennsylvania I am requesting that these additional exhibits become a part of the testimony before this committee: (1) a progress report of services to handicapped pupils, by category, showing the growth of programs since 1955, the projection of additional services for 1959-61 and the total number of estimated pupils to be served in each category; (2) a summary report of the number of pupils and programs in special education in the public schools of Pennsylvania, including current enrollment data; (3) a map of Pennsylvania showing where public school special education facilities are operated and indicating the areas of the State covered by such services.

3. Public support

We, in the Commonwealth of Pennsylvania, are pleased and proud to report that, under the leadership of our State government and legislature, State funds have been made available, since our mandated legislation, of adequate amount to permit the development of the much-needed facilities. To substantiate and extend this statement, I wish to provide for the record this graph indicating the biennial amounts appropriated by the State legislature for programs of exceptional children.

4. Per pupil costs

For purposes of the record also I wish to submit the following graph indicating comparisons between costs of educating handicapped children and normal children based upon the audit of expenditures for the school year 1958-59.

5. Overall enrollment

In order to enable the committee to compare the growth of special education programs with the overall of pupil enrollment in the public schools of Pennsylvania I am requesting that this summary of elementary and secondary enrollments be made a part of the record also. When these exhibits are compared it will be noted that 117,287 of the 1,914,496 public school children of Pennsylvania are participating in special education programs either on a full-time or part-time basis. In other words, 6 percent of the public school population of Pennsylvania receive services related to the specificity of their handicapping condition. These statements about special education are also of significance in evaluating the role of vocational rehabilitation services and indicate the extent to which such services are required to pick up the problems of the handicapped in later youth and adulthood.

6. Unmet needs

In spite of the rapid growth just described there are within the State of Pennsylvania four general areas of unmet needs as related to a comprehensive program for the handicapped. First, there is a need to increase full-time programs by the following amounts; for the trainable, 20 percent; for the mentally retarded educable of elementary school age, 25 percent; for the mentally retarded educable of secondary school age, 40 percent; and for the physically handicapped, including the sensory handicapped, 20 percent. Second, there is a need to increase itinerant services. In this connection the development of additional services is dependent on some improvement in our reporting and casefinding methods. However, we recognize the need for the services of 100 additional speech therapists, 150 additional teachers for the blind and partially sighted, and 100 additional teachers for the deaf and hard of hearing. Third, there is as yet no organized program or pattern of service for the socially and emotionally disturbed. A review of our public school population would indicate a need for 40 diagnostic teams and a minimum of 100 classrooms. Fourth, there is, as yet, no reimbursed program for the gifted.

We in Pennsylvania feel that these unmet needs are a State responsibility to a large degree. Their solution depends to a large degree on space, teachers, and continued financial support. We do feel, however, that some of them could and should be shared. Therefore, our present unmet needs become the bases for the following recommendations.

7. Recommendations

1. Consideration should be given to Federal support for teacher education programs in all areas where a critical shortage of teachers now exists. In the area of mental retardation the training of supervisors is now made available through Federal grants; such aid should be extended to classroom teachers in all areas of critical shortage. This support should be along two lines: to aid in the attainment of basic certification in a special field, either educational or vocational, and to others, who with further training may wish to enter or reenter teaching or counseling in one of the areas of the handicapped. In this connection it is necessary for us in Pennsylvania to oppose House bill 494. This may seem odd in that it sounds as though we oppose Federal aid for the preparation of teachers of the handicapped. This is not true, but we do oppose fragmentizing Federal aid for the teachers of the handicapped and believe such aid should be made available for all critical areas; that the administration of such aid should be within the U.S. Office of Education rather than the Office of Vocational Rehabilitation; and that all grants should be to college and university programs rather than residence schools.

2. Consideration should be given to additional Federal support for the extension of vocational rehabilitation services. In this connection we wish to voice Pennsylvania's support of House bill 3465 and to suggest two other ways in which we feel vocational rehabilitation services could be extended. There should be an extension of the term "employability" and a consideration of the extension of vocational rehabilitation services to nonhandicapped individuals. As an example there may even be gifted adults—those who never realized

their potential, those who are undergraded vocationally, those who have been deprived or failed to take advantage of proper education—such citizens also require and need vocational rehabilitation services.

3. Consideration should be given to research and study through additional pilot programs of the educational problems and needs of socially and emotionally disturbed children and youth.

4. Consideration should be given to two aspects of educational programing for the gifted; a change in title V of the NDEA Act extending guidance facilities into the elementary school, particularly those related to the identification of the gifted; and to a changing concept of the gifted, away from a "floor" in terms of measured mental ability and toward the concept of a given percentage of any school population.

5. Federal consideration should be given to the educational problems of migrant labor, both children and adults, with particular emphasis upon non-English speaking groups.

6. There should be continued national research toward the evaluation of present programs of both special education and vocational rehabilitation.

7. Direct financial aid should be considered for the establishment of regional libraries, curriculum studies, audiovisual aids, as well as demonstration centers for teachers and counselors of the handicapped.

8. The preparation of publications for use of the general public as well as for professional use is another necessary extension of services to be considered.

9. Consideration should be given to direct financial aid for ancillary services, particularly clinical and diagnostic.

10. There should be further coordination for distribution use, and improvement of services through aids and devices for all types of handicapped such as those now available to the blind and the deaf.

11. Proposed Federal legislation in regard to school buildings should take into account the needs of the handicapped as well as the nonhandicapped.

12. At all levels there should be closer coordination of special education and vocational rehabilitation services to eliminate overlapping, to cover the "gray areas," and to consolidate services for the handicapped into a life plan, with direct aid for experimentation through pilot programs of coordination of services at the State level.

Personally, may I again express my gratitude for this opportunity to speak for the Commonwealth of Pennsylvania in regard to these very important issues and to note with personal and professional pride the awakening of national interest in these areas.

Summary reports of numbers of pupils and programs in special education in the public schools of Pennsylvania

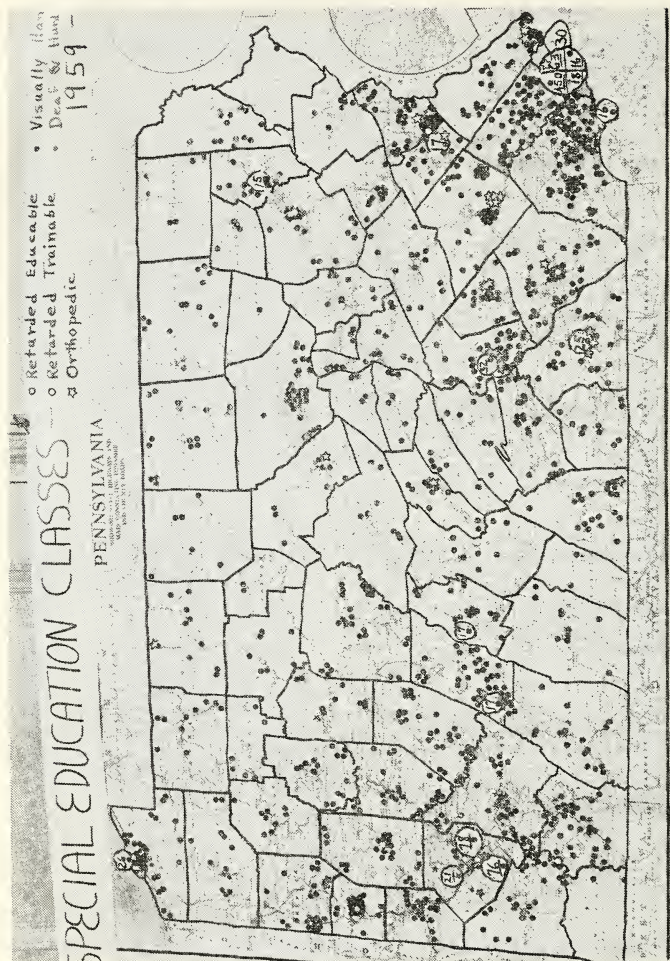
Type program	School year	County operated		District operated		Total	
		Classes	Pupils	Classes	Pupils	Classes	Pupils
Full-time programs: ¹							
Mentally retarded, elementary-----	1954-55	1	18	701	11,816	702	11,834
	1955-56	28	485	770	13,123	798	13,608
	1956-57	113	1,840	592	9,877	705	11,717
	1957-58	200	2,886	951	16,003	1,151	18,889
	1958-59	258	3,784	954	16,108	1,212	19,892
	1959-60	288	4,335	1,064	17,595	1,352	21,930
Mentally retarded, secondary-----	1954-55			118	2,909	118	2,909
	1955-56	3	72	150	3,780	153	3,852
	1956-57	26	646	586	9,329	612	9,975
	1957-58	64	1,287	310	6,462	374	7,749
	1958-59	105	2,021	293	6,701	398	8,722
	1959-60	111	1,990	418	8,642	529	10,632
Mentally retarded, trainable-----	1954-55	4	42	42	697	46	739
	1955-56	13	233	70	877	83	1,110
	1956-57	76	935	75	970	151	1,905
	1957-58	100	1,251	90	1,114	190	2,375
	1958-59	120	1,550	81	985	201	2,535
	1959-60	126	1,719	101	1,210	227	2,929
Physically handicapped-----	1954-55	2	26	93	1,207	95	1,233
	1955-56	2	35	101	1,441	103	1,476
	1956-57	21	242	99	1,756	120	1,998
	1957-58	31	366	105	1,762	136	2,128
	1958-59	39	422	120	1,946	159	2,368
	1959-60	43	449	110	1,416	153	1,865

¹ Child attends school the entire school day.

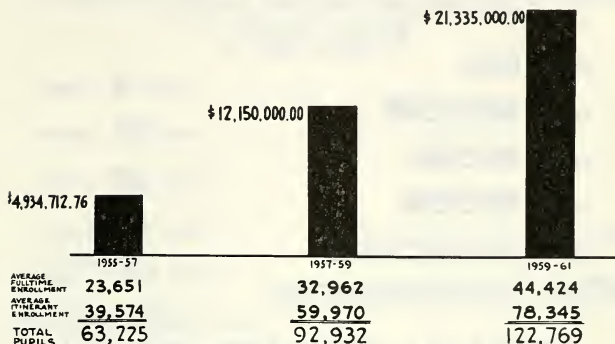
Summary reports of numbers of pupils and programs in special education in the public schools of Pennsylvania—Continued

Type program	School year	County operated		District operated		Total	
		Classes	Pupils	Classes	Pupils	Classes	Pupils
Deaf and hard of hearing-----	1954-55						
	1955-56						
	1956-57						
	1957-58	5	36	5	46	10	82
	1958-59	8	89	18	278	26	367
Blind and partially sighted-----	1959-60	9	77	34	290	43	367
	1954-55			33	634	33	634
	1955-56			27	484	27	484
	1956-57			27	340	27	340
	1957-58	1	6	27	271	28	277
Totals for full-time programs-----	1958-59	4	28	30	244	34	272
	1959-60	6	40	31	325	37	365
	1954-55	7	86	987	17,263	994	17,349
	1955-56	46	825	1,118	19,705	1,164	20,530
	1956-57	236	3,363	1,379	22,272	1,615	25,935
Part-time programs: ² Speech correction-----	1957-58	402	5,839	1,488	25,658	1,890	31,497
	1958-59	534	7,894	1,496	26,262	2,030	34,156
	1959-60	583	8,610	1,758	29,478	2,341	38,088
	1954-55	11	2,763	97	26,918	108	29,681
	1955-56	24	5,515	107	28,103	131	33,618
Hard of hearing-----	1956-57	65	14,213	126	29,112	191	43,325
	1957-58	115	24,621	105	26,992	220	51,613
	1958-59	186	37,594	112	28,009	298	65,603
	1959-60	217	47,635	123	29,836	340	77,471
	1954-55	2	103	28	308	30	411
Sight conservation-----	1955-56	1	93	26	318	27	411
	1956-57	10	415	31	358	41	773
	1957-58	7	323	26	308	33	631
	1958-59	10	611	25	358	35	968
	1959-60	27	847	8	190	35	1,037
Totals for part-time programs-----	1954-55	1	24	1	100	2	124
	1955-56	4	131	1	108	5	239
	1956-57	5	123	2	136	7	259
	1957-58	10	401	3	148	13	549
	1958-59	12	480	3	211	15	691
Totals for full-time programs and part-time programs-----	1959-60	13	2,866	125	27,226	138	30,092
	1954-55	26	5,632	134	28,521	160	34,153
	1955-56	79	14,759	158	29,578	237	44,337
	1956-57	127	25,067	133	27,436	260	52,503
	1957-58	208	38,606	140	28,515	348	67,121
	1958-59	256	48,962	134	30,237	390	79,199
	1959-60	20	2,952	1,112	44,489	1,132	47,441
	1954-55	72	6,457	1,252	48,226	1,324	54,683
	1955-56	315	18,422	1,537	51,850	1,852	70,272
	1956-57	529	30,906	1,621	53,094	2,150	84,000
	1957-58	740	46,500	1,636	54,777	2,378	101,277
	1958-59	839	57,572	1,892	59,715	2,731	117,287

² Child enrolled in regular school; receives special instruction in addition.



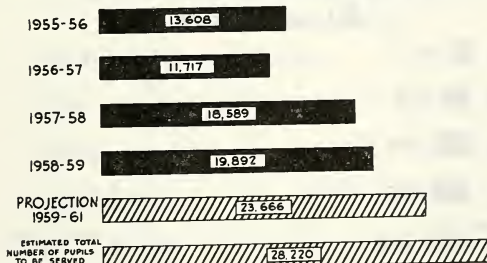
BIENNIAL APPROPRIATIONS *for* INSTRUCTION OF HANDICAPPED PUPILS



PROGRESS REPORT SPECIAL PUPIL SERVICES

1955-56 THROUGH 1958-59 SCHOOL YEARS

NUMBER OF PUPILS ENROLLED FULL TIME PROGRAMS
(Child attends *SPECIAL CLASS* the entire school day)
■ = 1000 CHILDREN



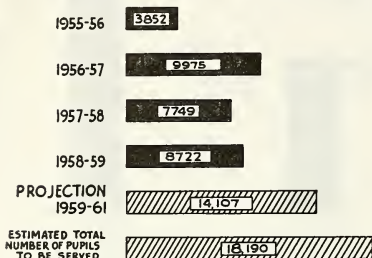
MENTALLY RETARDED EDUCABLE
ELEMENTARY

PROGRESS REPORT SPECIAL PUPIL SERVICES

1955-56 THROUGH 1958-59 SCHOOL YEARS

NUMBER OF PUPILS ENROLLED-- FULL TIME PROGRAMS
(Child attends SPECIAL CLASS the entire School day)

■ = 1000 CHILDREN



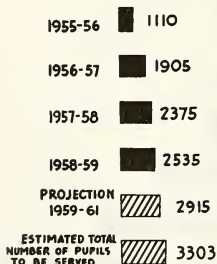
MENTALLY RETARDED EDUCABLE SECONDARY

PROGRESS REPORT SPECIAL PUPIL SERVICES

1955-56 THROUGH 1958-59 SCHOOL YEARS

NUMBER OF PUPILS ENROLLED-- FULL TIME PROGRAMS
(Child attends SPECIAL CLASS the entire school day)

■ = 1000 CHILDREN



MENTALLY RETARDED TRAINABLE

PROGRESS REPORT SPECIAL PUPIL SERVICES

1955-56 THROUGH 1958-59 SCHOOL YEARS

NUMBER OF PUPILS ENROLLED -- FULL TIME PROGRAMS
(Child attends SPECIAL CLASS the entire school day)

■ = 1000 CHILDREN

1955-56 ■ 1476

1956-57 ■ 1998

1957-58 ■ 2128

1958-59 ■ 2365

PROJECTION
1959-61 ▨ 2600ESTIMATED TOTAL
NUMBER OF PUPILS
TO BE SERVED ▨ 2827

PHYSICALLY HANDICAPPED

PROGRESS REPORT SPECIAL PUPIL SERVICES

1955-56 THROUGH 1958-59 SCHOOL YEARS

NUMBER OF PUPILS ENROLLED -- FULL TIME PROGRAMS
(Child attends SPECIAL CLASS the entire school day)

■ = 1000 CHILDREN

1955-56 | REPORT NOT AVAILABLE

1956-57 | REPORT NOT AVAILABLE

1957-58 | 82

1958-59 | 367

PROJECTION
1959-61 ▨ 650ESTIMATED TOTAL
NUMBER OF PUPILS
TO BE SERVED ▨ 882

DEAF OR HARD OF HEARING

PROGRESS REPORT SPECIAL PUPIL SERVICES

1955-56 THROUGH 1958-59 SCHOOL YEARS

NUMBER OF PUPILS ENROLLED... FULL TIME PROGRAMS

(Child attends SPECIAL Class the entire School day)

■ = 1000 CHILDREN

1955-56	REPORT NOT AVAILABLE
1956-57	REPORT NOT AVAILABLE
1957-58	29
1958-59	237
PROJECTION 1959-61	486
ESTIMATED TOTAL NUMBER OF PUPILS TO BE SERVED	596

BLIND OR PARTIALLY SIGHTED

PROGRESS REPORT SPECIAL PUPIL SERVICES

1955-56 THROUGH 1958-59 SCHOOL YEARS

NUMBER OF PUPILS ENROLLED... PART TIME PROGRAMS

(Child attends REGULAR SCHOOL Receives Special instruction in addition)

■ = 10,000 CHILDREN

1955-56	35,618
1956-57	43,325
1957-58	51,613
1958-59	65,603
PROJECTION 1959-61	85,600
ESTIMATED TOTAL NUMBER OF PUPILS TO BE SERVED	90,586

SPEECH HANDICAPPED

PROGRESS REPORT SPECIAL PUPIL SERVICES

1955-56 THROUGH 1958-59 SCHOOL YEARS

NUMBER OF PUPILS ENROLLED... PART-TIME PROGRAMS

(Child attends REGULAR SCHOOL Receives SPECIAL Instruction in addition)

■ = 1000 CHILDREN

1955-56 ■ 411

1956-57 ■ 773

1957-58 ■ 631

1958-59 ■ 969

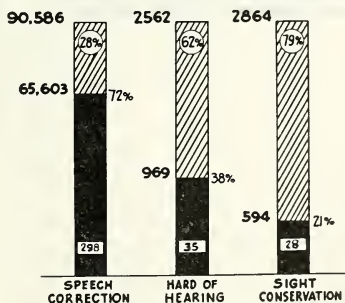
PROJECTION
1959-61 ▨ 1571ESTIMATED TOTAL
NUMBER OF PUPILS
TO BE SERVED ▨ 2562

HARD OF HEARING

PROGRESS REPORT SPECIAL PUPIL SERVICES

1958 - 1959

PART TIME PROGRAMS

(Child attends REGULAR SCHOOL - Receives SPECIAL INSTRUCTION in addition)

HOME BOUND INSTRUCTION

(Child unable to attend SCHOOL - Receives INSTRUCTION in the HOME)

3758

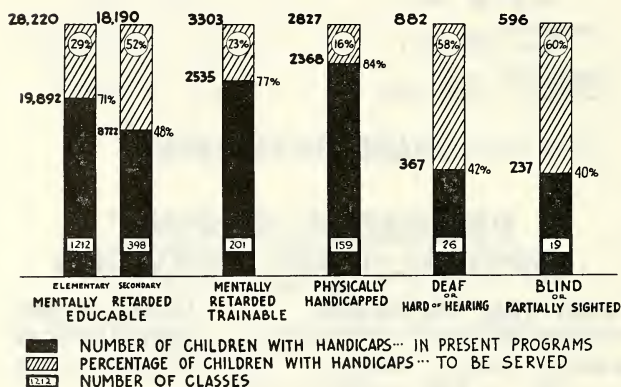
CHILDREN KNOWN TO BE
RECEIVING HOME BOUND INSTRUCTION

■ NUMBER OF CHILDREN WITH HANDICAPS ... IN PRESENT PROGRAM
 ▨ PERCENTAGE OF CHILDREN WITH HANDICAPS... TO BE SERVED
 ■ NUMBER OF TEACHERS

PROGRESS REPORT SPECIAL PUPIL SERVICES

1958 - 1959

FULL TIME PROGRAMS

(Child attends SPECIAL CLASS entire school day)

PER PUPIL INSTRUCTIONAL COSTS FOR CHILDREN
IN SPECIAL CLASSES OPERATED BY COUNTY SCHOOL BOARDS

1958 - 1959 Averages of Budget Reports

\$270.28

Regular Elementary Pupil Average
1957 - 1958

\$382.93

Mentally Retarded Elementary

\$383.01

Regular Secondary Pupil
Average 1957 - 1958

\$735.06

Mentally Retarded Trainable

\$388.74

Mentally Retarded Secondary

\$857.60

Blind and Partially Sighted

\$857.63

Deaf and Hard of Hearing

\$1,152.69

Physically Handicapped

Mr. ELLIOTT. The gentleman from Minnesota, Mr. Quie.

Mr. QUIE. Do you also have a report to substantiate further those 12 points that you make, background material of why you make those statements? If you do not, I would like to visit with you afterward.

Dr. DICE. I will be glad to visit with you afterward anyway. I think the material which I submitted on education will support the statement I have made.

The written reports from our department of welfare will pick up on the aspects of welfare and vocational rehabilitation from our State, will give subsequent testimony which will support their point of view.

Since I was the representative of the Governor we felt it advisable in working out our testimony that all the recommendations be made at once with substantiating data to appear later.

Mr. ELLIOTT. The gentleman from Connecticut, Mr. Giaimo, has a question.

Mr. GIAIMO. Dr. Dice, you mention the four needs in this area that presently must be met. I gathered that you feel there must be Federal assistance in meeting these four needs. Is that correct?

Dr. DICE. I presented those four unmet needs as our needs as far as the State is concerned. We feel we have certain responsibilities along these lines.

The actual provision of educational facilities for these types of children we feel, is our State responsibility. We do feel that in order that the State can carry its share of the responsibility the kinds of aid which I have suggested from the national level would make program making easier and quicker in these particular areas.

Mr. QUIE. I did want to make that clear, that you are recognizing the responsibility of the States, also, in this field.

Dr. DICE. Right; very definitely. I think this is a shared responsibility.

Mr. ELLIOTT. Thank you, Dr. Dice. Your testimony will be very helpful to us.

At this time I have a telegram from Mr. William J. Jones, Administrator of Union Essex Institution of Elizabeth, N.J., saying that due to circumstances beyond his control he is unable to appear before our committee on Thursday, and he wishes to express his regrets and to express appreciation for our invitation.

I quote from the telegram:

I certainly endorse the principles to which your group is dedicated in seeking to expand aid to the handicapped and trust my inability to attend will cause you no inconvenience.

It is signed "William J. Jones."

Mr. ELLIOTT. It has been called to my attention that the president of the Jersey City Board of Education is in our audience. I am going to ask Congressman Daniels to present him for a word.

Mr. DANIELS. Mr. Chairman and colleagues, I note in the audience a representative from the Jersey City Board of Education, President John Sheehan, a distinguished businessman and mechanical engineer by profession.

Having been born and reared in Jersey City, personally, and being a product of the Jersey school system, I am naturally very proud of our school system, and also of the many facilities and services that our

Jersey City Board of Education provides in the field of special education and rehabilitation.

I am quite sure that Mr. Sheehan, as president of the Jersey City Board of Education, will have a fine message for the benefit of this subcommittee's study.

I am privileged to present to you Mr. Sheehan.

Mr. ELLIOTT. We are very happy to hear you, Mr. Sheehan. We appreciate your coming down.

STATEMENT OF JOHN SHEEHAN, PRESIDENT, JERSEY CITY BOARD OF EDUCATION

Mr. SHEEHAN. I have a statement that I have written up in a hurry. I can give it to the reporter if you don't want me to read it.

Mr. ELLIOTT. You may read it if you care to.

Mr. SHEEHAN. It is just the philosophy of the board with the idea of our social feeling in this whole field of educating the children, retarded children.

But in order not to take up too much time, I will give the reporter that philosophy.

(The statement referred to follows:)

STATEMENT OF JOHN SHEEHAN, PRESIDENT, JERSEY CITY BOARD OF EDUCATION

In dealing with the social question, many people are still far too much inclined to regard it simply as a problem affecting the workingman.

The word "social" refers to whatever is connected with "society" in the community and this has reference to all of the members of the community. Within a country, the social problem comes nearer to a solution in proportion as the citizens have a chance to carry on the work that is suited to their ability and are enabled to secure for themselves such a share of the fruits of the common activity as corresponds to their real needs. We see, therefore, that the social question is not limited to the interests of a single class in the various countries, but involves the creation of such a healthy order in the national life as a whole as will be of service to all of the citizens.

Real social progress consists in making it possible for all to have access to the vital members which have been called the initial equipment without which a man cannot go forward to the fulfillment of his destiny and which are related to the basic elements of the law of life.

All man stand in need of (and are entitled to) such health care as is scientifically and technologically possible. This involves the problem of social health services such as will enable everybody to get the treatment they need. All must have a chance and the means to obtain the kind of training that is suited to their respective aptitudes.

Here we are faced with the democratization of education. Those benefits are not meant to be the privilege of a minority but must be the heirloom or prerogative of all men. For the first time in history the more advanced societies can provide all that is needed to attack the social problem in its broadest meaning. It is not surprising, therefore, that in those countries the problem of vital necessities for all of the people has given rise to a "grande politique" concerning a better distribution of national income, the creation of social health facilities and the steps required to provide all of the children with the kind of education that is suitable to them.

Mr. SHEEHAN. I would like to talk to you just off the cuff about a situation that I think has developed and is developing throughout this State. I don't know whether it has developed all over the country or not.

But I think we have a much better opportunity to talk about what has been done for this type of child than probably any other community that I know of.

I don't know if you know, but we have a special school on the boulevard, which is across the street from the Jersey State Teachers College, called the A. Harry Moore School, which was named after our former Governor, A. Harry Moore.

This school was established in 1921 and it is a public day school for the physically handicapped, from the kindergarten through grade 10.

The enrollment in that school runs in the neighborhood of 300 children. There are cerebral palsy cases, 93; general orthopedic, around 100; and cardiopathic runs in the neighborhood of a hundred pupils in this particular school.

Now, the services are elementary and secondary curriculum; they have home economics, industrial arts, mechanical dentistry, power sewing-machine operation, watch repairing, special typing, guidance clinic, physical therapy, occupational therapy, speech therapy, physical education, muscular therapy; and we also have a summer camp for them and we also have job placement.

The school hours are from 8:30 to 3:15 a day.

Now I would like to tell you that in addition to the A. Harry Moore School in the year 1958-59 we had 24 special classes scattered throughout the city in the various schools, and this year we have increased it by five more classes; we have 29 classes.

These cover the educable mentally retarded, the trainable mentally retarded, deaf, hard of hearing, blind, and partially seeing.

So that in our entire system we have a little over 32,000 children, and covering the A. Harry Moore School and in these classes that we have in these schools we have about 700 children that we cover every day from around 8:30 to 3:15.

Now I would like to tell you what it costs us. It costs us alone in the A. Harry Moore School in the year 1958-59, \$455,814.

In the other children that we have scattered around the various schools our costs there were \$305,512.

Now, this year we will have five additional classes, which will cost about \$12,000 a class, which will increase that cost \$60,000, and we gave on July 1, 1959, an increase in salary to the teachers of these children of \$23,600, which brings our total cost to \$912,040, for all of these children.

In addition to that, I might say to you that we take approximately 100 children from the other communities.

You probably know that a town like Ridgewood is a very wealthy town: a town like Montclair is a very wealthy town. They send pupils to us for these courses because they do not have the facilities.

Now, the main reason why I bring up the cost of this particular program here is the fact that this is budget time, and we are being attacked indiscriminately, I would say, by very powerful forces as to the cost of our educational system.

As you probably know, this city is governed by five commissioners. Two of these commissioners have been against any increased cost in the school system and have been attacking it.

In fact, one of them, Commissioner Murray, at this school board meeting, last week—

Mr. DANIELS. Pardon me, Mr. Sheehan. I do not think that this would be an appropriate forum to discuss personalities. If you desire to furnish the members of the committee with testimony as to the costs

of special education classes, the cost per pupil (I was quite fascinated by the figures you mentioned this morning and I intended to ask you several questions with regard thereto), you may do so, but I would respectfully ask you to refrain from engaging in any discussion about politics in Jersey City so far as that affects our Jersey City school system, because I do not think that is any concern of this committee.

This committee is interested in the unmet needs in the fields of special education and the problems of rehabilitation and not in any matter which might concern the citizens of Jersey City with respect to its political problems.

Mr. SHEEHAN. All right.

Mr. DANIELS. I trust I am in order, Mr. Chairman.

Mr. ELLIOTT. You may proceed.

Mr. SHEEHAN. The point that I would like to try to get over without bringing in personalities are things that I feel as president of the board I should lead and you as Congressmen should lead to because I think this is attack on the cost per child.

Now, I do agree that the real estate throughout the country, the people who own their homes and the plants and all, are paying in taxes to support these children. I think that we probably could get some relief from the Federal Government.

As Governor Rockefeller mentioned, if we could get the 10-percent tax on the telephone it would help this problem.

But, you see, you have people combating this and you also have the apathy of the people; I mean the parents do not seem to have too much interest in this whole program.

They just are apathetic about it. We just recently had a book fair where we bought a tremendous amount of books, in fact, we bought \$5,000 worth of books alone for the A. Harry Moore School.

We invited the parents to come every day and to come at night to see them. It was really terrific; hardly any parents showed up.

I mean there is an apathy. So that in trying to put this program over that you want to educate these children so that they can be fitted for their place in society and the general run of people, and the parents in particular do not seem to have any interest in helping them.

Now, we are faced with the situation that this program costs us, our budget runs between 14 and 15 million dollars, and we are spending approximately a million dollars on this program alone, from these figures, but this does not cover all the cost.

The attendant cost for that school and part of the bus transportation are not included in these figures.

Now, for us to stand here and try to make this program grow and take in more children, we have to combat the cost. Of course, I will agree that they have many, many arguments in their favor, that the property should not have to bear the total cost, the real estate taxes should not have to bear the total cost.

I think the Government should help out in the program.

Mr. ELLIOTT. May I ask you, Mr. Sheehan, do you have any figures as to the number of handicapped children who are not now served by special educational classes in your city?

Mr. SHEEHAN. Yes, I have the total.

Mr. ELLIOTT. Will you make those figures available for our record immediately following your testimony?

Without objection, the figures which you have will be made a part of our record for further consideration.

(The figures referred to follow :)

A. HARRY MOORE SCHOOL,
Jersey City, N.J

PUBLIC DAY SCHOOL FOR THE PHYSICALLY HANDICAPPED

KINDERGARTEN TO GRADE 10

Enrollment

Cerebral palsied-----	93
General orthopedic-----	97
Cardiopathic-----	93

SERVICES OF THE A. HARRY MOORE SCHOOL

Elementary and secondary curriculum

Home economics	Physical therapy
Industrial arts	Occupational therapy
Mechanical dentistry	Speech therapy
Power sewing machine operation	Physical education
Watch repair	Musical therapy
Special typing	Summer camp
Guidance clinic	Job placement

School hours, 8:30 to 3:15.

Mr. SHEEHAN. Another thing I might tell you that across the street from the A. Harry Moore School, we have the Jersey City State Teachers College. Last September they were able to start a new course in the State of New Jersey. They are now giving a course for teachers to be trained in handling this type of child and they will be able to certify them at the end of 4 years to teach mentally retarded children and they are using the A. Harry Moore School as a workshop for these teachers.

It just so happens that this is the only State teachers college in the State of New Jersey that has a school like this across the street so that they are able to do it.

So we are very happy to cooperate with the State and let them use our facilities as a workshop.

So we do not want to give this up; we want to hold on to it and make it even better.

I feel that you and I have to lead. Even if we turn around and no one is following us, we have to keep going forward and doing something for these children.

As I say, we are attacked on the basis that our cost per child is high, but when you look at this deal alone it is costing us in the neighborhood of \$35 to \$40 a child to educate these children, I mean if we did not do it we could reduce our cost per child from say, \$450 down to about \$410, and, therefore, you cannot compare the cost per child in this city with other towns that do not give this service.

It is not a fair comparison. So I cannot tell you too much.

If you would hear as a witness today, I would like Miss Thompson, who is principal of the A. Harry Moore School, to talk to you about her particular problems.

Mr. ELLIOTT. Is Miss Thompson on our list of witnesses?

We will be glad to hear Miss Thompson at some point during the hearings.

MR. SHEEHAN. I would like to close 1 more minute by saying to you this, that there is one thing that everybody is concerned about. I understand from Miss Thompson that the people in Pennsylvania and the surrounding States are also worried about it.

It is a very difficult thing to get therapists for this school. I understand it is difficult in Pennsylvania, in New Jersey, New York, and if the Government could do something toward subsidizing some sort of school or recruiting of people to take up this physical therapy we could use many more people in the A. Harry Moore School, but we have a very difficult time trying to find people who are trained for that.

Miss Thompson tells me that there are some schools, but they haven't any people to give us, they already have been contracted for.

There is another thing in the laws that these people are offered usually a very low wage. There is a big argument against paying them a starting salary comparable to what a teacher would get. Although they are not educated in Brahms, Beethoven, mathematics, or chemistry; they are trained in a particular field that is quite necessary for these children.

We are all working under a handicap. So when you are thinking about legislation if you could devise some type of program where you could recruit people for this and subsidize training schools, even if we try to set up here in Jersey City in our medical center a sort of little school to train these people, and also help us toward subsidizing the cost of paying these people.

MR. ELLIOTT. The gentleman from New Jersey.

MR. DANIELS. I believe you testified that there are approximately 300 students in the A. Harry Moore School?

MR. SHEEHAN. Yes.

MR. DANIELS. They are suffering from various disabilities, physical, heart, coronary and speech defects, hearing, and so forth?

MR. SHEEHAN. Yes.

MR. DANIELS. How many teachers do you have in that school and in what areas do they teach?

MR. SHEEHAN. We have 16 that cover general orthopedic. This is in 1958-59; five in cerebral palsy; eight in cardiopathic. We have 15 in educable mentally retarded.

We have nine in trainable mentally retarded.

Two for the deaf; one for hard of hearing; one for blind, and two for partially seeing.

MR. DANIELS. What is the approximate size of each class?

MR. SHEEHAN. That I could not tell you. I think it varies under the State law, that you can have, say, only so many deaf per teacher.

Miss Thompson could supply that answer.

MR. DANIELS. In the year 1958-59 they had 24 classes throughout the Jersey City school system which was subsequently increased by 5 and that the total cost of the A. Harry Moore School for these 29 classes amounted to approximately \$912,000.

MR. SHEEHAN. That is right.

Mr. DANIELS. That does not include the cost of transportation of these students to and from school?

Mr. SHEEHAN. The reason I do not include that, we get about 75 percent of that back from the State on the buses, so we don't include that.

Mr. DANIELS. Do these figures encompass the entire disabled student body of Jersey City?

Mr. SHEEHAN. I would not say that it covers them all.

Mr. DANIELS. Are there some students that receive home care, home study?

Mr. SHEEHAN. We have a home instruction course, too.

Mr. DANIELS. That is in addition to these figures?

Mr. SHEEHAN. That is in addition to these. And hospital instruction, too.

Mr. DANIELS. From your experience, do you find a shortage of specialized people in these various fields?

Mr. SHEEHAN. That is right. But this is being helped now by this new course at the Jersey City State teachers which started last September.

But the State of New Jersey won't feel the impact of that until about 4 or 5 years from now, because this is the first course that started and it lasts 4 years.

Mr. DANIELS. Does the State of New Jersey give any aid to the local boards of education with respect to these particular areas of special education?

Mr. SHEEHAN. They do, but it is very minute.

These figures that I give you are the figures that we pay, ourselves, without any aid. That is why I did not include transportation.

Any aid that is given us is subtracted and is not in these figures.

Mr. DANIELS. What is the per pupil cost in this special area?

Mr. SHEEHAN. In general, orthopedics the per-pupil cost runs around \$1,349, cerebral palsy runs around \$1,649. Cardiopathic runs around \$1,450. Educable mentally retarded, \$954. Trainable mentally retarded, \$1,234. And the deaf, \$1,335. Hard of hearing, \$1,280. And the blind, \$1,926. Partially seeing, \$850 per child.

Mr. DANIELS. Per annum?

Mr. SHEEHAN. Yes.

(Table submitted by Mr. Sheehan follows:)

1958-59 cost per pupil by type of class, day school only

Type of class	Average enrollment	Number of teachers	Tuition cost per pupil per form No. 11	1959-60 tuition rate charged by board	Total tuition cost	Number of tuition pupils	Remarks
Entire system.....	30,403.3	1,420.1	\$479.66	\$400	-----	-----	
Elementary.....	22,633.7	980.2	447.36	1,475	-----	-----	
High school.....	7,829.6	439.9	573.06	2,525	-----	49	
General orthopedic.....	182.0	16.0	1,349.65	1,300	\$259,132.80	88	} Total cost of operating A. Harry Moore School, \$455,814.09. } Total cost of educating mentally retarded pupils, \$305,512.24. }
Cerebral palsy.....	41.0	5.0	1,649.37	1,300	67,024.17	-----	
Cardiopathic.....	89.0	8.0	1,450.08	1,300	129,057.12	-----	
Educable mentally retarded.....	196.0	15.0	954.22	1,300	187,027.12	-----	
Trainable mentally retarded.....	96.0	9.0	1,234.22	1,200	118,485.12	2	
Deaf.....	16.0	2.0	1,335.97	1,200	21,375.52	4	
Hard of hearing.....	10.0	1.0	1,280.14	1,200	12,280.14	2	
Blind.....	5.0	1.0	1,926.81	1,200	9,634.05	2	
Partially seeing.....	28.0	2.0	850.80	800	23,822.40	-----	
Total.....	663.0	-----	-----	-----	828,440.44	-----	
5 additional classes at \$12,000.....	-----	-----	-----	-----	60,000.00	-----	5 more at \$12,000 a class: \$60,000 plus \$305,512.24 equals \$365,512.24.
Total.....	-----	-----	-----	-----	888,440.44	-----	
Double increment granted to teachers on July 1, 1959, would increase this cost by approximately.....	-----	-----	-----	-----	23,600.00	-----	
Total.....	-----	-----	-----	-----	912,040.44	-----	

¹ Academic.² Industrial.

Mr. DANIELS. How do those figures compare with the normal student?

Mr. SHEEHAN. In 1958-59 our average cost was \$450 per pupil. That included this, so if you quickly subtracted the \$912 from our total budget and divided by the total number of children, I would say you would reduce that \$450 figure in the neighborhood of \$35 or \$40.

In other words, you would reduce it from \$450 to about \$410.

Mr. DANIELS. From your testimony I take it that there is a dire need of assistance to our local boards of education from other areas, either State or Federal?

Mr. SHEEHAN. Right.

Mr. DANIELS. And that there is a great shortage of specialists in the various fields of therapy as well as teachers for these groups?

Mr. SHEEHAN. I would say physical therapists is the biggest need and then the need of training and certifying teachers for this program is big, too, but that is being corrected now by this course, as I said before, in the Jersey City State Teachers College.

Mr. DANIELS. I have one further question, Mr. Sheehan: Do you have any difficulty in recruiting teachers in these special areas by reason of the fact that the compensation is not sufficient, or adequate?

Mr. SHEEHAN. Well, we have not had any problem there. The thing that amazes—it does not amaze me, because there are a great many people, as you know, Congressman, that are dedicated people, and we have a great many teachers that are dedicated and the fact that you give them a raise or you don't give them a raise does not make any difference to—

Mr. DANIELS. I do not mean on that score. Is our pay scale here in Jersey City comparable to other areas?

Mr. DANIELS. We do not experience difficulty in acquiring the necessary specialists in these areas by virtue of the fact that our pay scale is inadequate; is that true?

Mr. SHEEHAN. The only field that I would say it is inadequate and that is in the physical therapists and they are not teachers. That is where it is inadequate.

Mr. DANIELS. Thank you.

Mr. ELLIOTT. The gentleman from Minnesota, Mr. Quie, has a question.

Mr. QUIE. You did not state specifically how much aid you received. Could you give this? Is it an amount so many per pupil? How do you receive the aid from the State?

Mr. SHEEHAN. We receive the aid from the State in specific areas. For instance, bus transportation for these children, they would give us 75 percent of it.

But that does not amount to too big a figure.

Mr. QUIE. You say 75 percent does not amount to too much?

Mr. SHEEHAN. That is right. This is a city and they don't have to travel too far on the buses.

Mr. QUIE. They pay 75 percent of the transportation cost?

Mr. SHEEHAN. Yes.

Mr. QUIE. Discounting transportation cost, what other State aid do you receive for education of your children?

Mr. SHEEHAN. I would say in our home program—you catch me unawares on this figure—it would run a couple of million dollars.

Mr. QUIE. Is this according to State law so much per child, or how is it determined?

Mr. SHEEHAN. It is determined by different areas, like, for instance, if you have a course like we have at one of the schools at night, teaching Americanization courses, they allow you so much money for that.

Mr. QUIE. I mean for the handicapped children.

Mr. SHEEHAN. You are talking of handicapped only?

Mr. QUIE. Yes.

Mr. SHEEHAN. The amount is very small. I would say that offhand the bus transportation—

Mr. QUIE. Not transportation, but discounting transportation, what State aid do you receive for the handicapped?

Mr. SHEEHAN. I can get the figure for the committee and send it up to you.

Mr. QUIE. But there is some?

Mr. SHEEHAN. There is some.

Mr. QUIE. Are there any students outside of the school district who are handicapped who go to your school?

Mr. SHEEHAN. There are approximately a hundred that come from outlying Montclair, Ridgewood.

Mr. QUIE. That means that they do not provide that kind of classes in Montclair and Ridgewood?

Mr. SHEEHAN. That is right. They send them here.

Mr. QUIE. They pay the cost of education for the handicapped?

Mr. SHEEHAN. We charge them a tuition fee.

Mr. QUIE. So for anybody out of the district, there is no added expense to you?

Mr. SHEEHAN. Well, it is because, Congressman, the amount of tuition that we charge these towns has been a great deal less than our cost.

Mr. QUIE. Why don't you charge them the full amount of the cost?

Mr. SHEEHAN. Well, we did move it up a little bit this year toward it. You know, sometimes it is a kind of shock to them if you try to give it to them all in one year, but we have been gradually now in the last year trying to move it up more toward that cost because they have budget problems, too.

So we have to recognize that we have our budget problems, so we recognize that they have theirs. So we just try to say to them, well, can't we move it up a little bit this year and maybe the following year move it up a little.

Mr. QUIE. Are you prevented at all by State law from charging the full amount of the tuition?

Mr. SHEEHAN. No.

Mr. DANIELS. Mr. Sheehan, on that question of cost charged to the other municipalities for their students, is there any particular reason why Jersey City should subsidize the public communities in the education of their handicapped?

Mr. SHEEHAN. No, there isn't.

It so happens that this school has been such a wonderful school and so recognized all over and there has been a sort of attitude that if somebody came with a polio case or cerebral palsy case, that if there was an opening they did not want to deny it to those communities if they had room for them.

Mr. DANIELS. Approximately what do you charge these other communities for the tuition in education of special children?

Mr. SHEEHAN. It was under a thousand dollars, but we have moved it up to, for instance, cerebral palsy where it costs us \$1,650, we have now this year moved up to a tuition cost of \$1,300. So we are \$350 a child under what it costs us in that area.

But that has been a gradual moveup. It was much lower than that.

Mr. QUITE. Are there any other school districts in the State that provide special classes in the public schools for handicapped?

Mr. SHEEHAN. I think there are, but I could not tell you because I am not technically equipped to give you an answer. I think Newark does.

Mr. QUITE. Now, for the teacher-training course in the teachers college: This is only for teachers of the mentally retarded. Is that right?

Mr. SHEEHAN. This program would cover all the types of children that are in the A. Harry Moore School.

Mr. QUITE. You mean the teachers-training course in the teachers college is training teachers for all the handicapped?

Mr. SHEEHAN. My understanding is—I think it would be better if you could get the courses of study from Dr. Gilligan, who is president of the Jersey City State Teachers College.

You see, I don't know whether it covers all of them. I thought it did. When we made the agreement to let them have the school, to use as a workshop, we agreed that they could give all the courses they wanted there.

Mr. ELLIOTT. Thank you very much, Mr. Sheehan.

I neglected to say earlier that the clerk of our subcommittee is Dr. Harry Barnard. Dr. Barnard is here in this room. If anyone has business with the subcommittee, they can contact him.

Also, we are assisted by Miss Alice Hartman. Miss Hartman is here at the table at my left, an employee of the subcommittee, and those who have business with the subcommittee may talk to Dr. Barnard or Miss Hartman, either one, or both.

Also, Congressman Daniels' aid, Mr. Obendorf, is here and also Mr. Griffin. These gentlemen are aids of Congressman Daniels and they are available also to aid the hearings as we proceed here.

I would like to bespeak my thanks for their aid and service in this endeavor.

Our next witness is Mr. Jack Matthews, chairman of the Speech Department of the University of Pittsburgh.

Mr. Matthews, if you could summarize your statement and then submit your written statement for the record, it would be helpful to us in trying to meet our time schedule. At this time I am going to ask Congressman Daniels, the ranking member of the subcommittee present, to preside.

Congressman Daniels.

Mr. DANIELS (presiding). Mr. Matthews, you were due here earlier this morning—

Mr. MATTHEWS. I am sorry, I just arrived about 15 minutes ago.

Mr. DANIELS. Because of the fact that we have scheduled 30 witnesses to testify here today and time is running along and we are about

an hour behind schedule now, I must limit the testimony of each witness to no more than 10 minutes.

If you have a prepared statement and desire to submit the statement and summarize the views expressed in your statement, you may do that, or you may proceed with the statement, but I will have to limit you to no more than 10 minutes in your testimony.

Mr. MATTHEWS. I understand.

Mr. DANIELS. You may proceed.

STATEMENT OF JACK MATTHEWS, CHAIRMAN, SPEECH DEPARTMENT, UNIVERSITY OF PITTSBURGH

Mr. MATTHEWS. First of all, I want to express my appreciation from someone interested in special education for the real contribution that I think your subcommittee is going to make to our field.

I don't know of any time in the history of our field when such a soul-searching look has been taken at the needs that exist in this particular field.

You gentlemen already have lots and lots in the way of statistics, facts, and figures, and more will be submitted in writing as these hearings go on.

I would like to talk not so much in terms of statistics, I would like to talk in terms of people, in terms of some of the human values that I happen to be interested in as someone who has worked in the broad field of rehabilitation and special education for about 20 years.

The viewpoints that I am expressing are those which I personally have as a father, as a professional person who has been training people in the area of rehabilitation and special education for a number of years, as well as a member of a number of professional organizations interested in this field.

I don't for one moment want to say I am speaking officially for the American Association for Cleft Palate Rehabilitation or the National Association for Retarded Children, or the American Speech and Hearing Association, or the Pennsylvania Speech Association, or any of these other organizations to which I belong, and which I have had the honor of serving in various offices and various capacities.

But the statements I do want to make I think will reflect pretty largely the points of view of my professional colleagues, particularly in the State of Pennsylvania.

I currently am serving as president of the Pennsylvania Speech Association and although we have not taken any official action in terms of the subject matter under discussion today, I do think that I can fairly accurately reflect the views of a number of these organizations and these workers.

If I were to summarize the views of these people, I would say that it would boil down largely to this fact: That we have today in the area of common disorders—I am speaking now of speech and hearing disorders, about which we have a great deal of knowledge and information that is available to us that can be used to help handicapped children and adults in the field of speech and hearing disorders.

But the disconcerting thing, the frustrating thing to those of us in this field is that although we have the know-how to help many

individuals, we don't have enough hands to provide the services that are needed.

Specifically, let me give you some illustrations of the kind of things that happen to me day in and day out at our clinical facilities at the University of Pittsburgh where we are training a fairly large number of people to go into various aspects of special education.

Two days ago a woman came in from about 75 miles from Pittsburgh, tears in her eyes because her husband, a chap not much older than I, had had a heart attack. As a result of this he was aphasic. There was not a speech pathologist within 80 or 100 miles of this particular person to help this individual to regain his speech in order that he could stand on his own two feet, earn a living, and resume normal activity.

Had that person been in the city of Pittsburgh where there were clinical facilities, where there were adequately trained people to help, there was a good chance he could have been restored to a useful productive life.

The same sort of thing happens day after day.

When we see children coming from the outlying sections of Pennsylvania, from rural communities, or from smaller communities where there are not adequate services for speech and hearing handicapped, we are forced day after day to say to these people, when they ask, "Can't you do something," we say, "If you were here close to our clinic we would be glad to help you. We would love to be of some service."

Then they will say, "Can't you refer us to someone in our own home community?"

Time after time we are forced to say, "We are sorry; there is no one there."

This is not because the local communities are necessarily uninterested in providing the service. It is not because the local community is lacking in funds, but it is this old bugaboo that comes up in every one of these areas, the matter of personnel.

I just completed a term as president of the American Association for Cleft Palate Rehabilitation, an organization made up of surgeons, of dental specialists, special therapy people, psychologists, interested in rehabilitation of cleft palate individuals.

Time after time we are confronted throughout the country in our clinic facilities where excellent surgical results have been accomplished, where the dentists have done a fine job and now what is left is the rehabilitation to be carried on by the special specialists.

Time after time we are confronted with this same problem that I just mentioned; we don't have the trained personnel to do the job.

Mr. DANIELS. Is that due to a shortage of teachers in that particular area?

Mr. MATTHEWS. Very much so, sir. It is a matter of—roughly, our best national estimates say that we need approximately 20,000 speech pathologists to perform the bare necessities of rehabilitation work in the speech field for children and adults.

Mr. DANIELS. How many are available?

Mr. MATTHEWS. We have about 2,000 qualified people in the country today. We need about 1,500 new people to be trained each year to replace those who leave by marriage, retirement, and so on.

We are turning out 400. Now, those folks who will probably testify later on today about the needs in cerebral palsy, about the needs in the area of mental retardation, I am sure will agree with me that many of these youngsters or many of these adults with these afflictions also have speech problems.

Roughly two-thirds of our cerebral palsy individuals will have speech disorders. A very high percentage of mentally retarded have both speech and hearing problems.

Now, these individuals have a couple of strikes against them. The mental retardation plus the speech problem can be a real, real serious problem.

On the speech handicapped can be the difference between mentally retarded person making some kind of adjustment in the community and not making the adjustment and staying on the relief rolls or on the county welfare rolls for the rest of his life.

Now, I do not think it is necessary to belabor this particular point. It is not unique in the field of speech, certainly. I am sure you will find this same sort of thing existing in most of the specialty fields you will be dealing with today.

I think the thing to ask, at least the thing we have been asking ourselves, is what are we going to do about it. We have tried in our own particular training center at the University of Pittsburgh to secure outside funds from various sources, from public and private agencies, to provide scholarships and fellowships to encourage people to come into this field.

We had some success with this.

In a matter of a few years with the outside financial aid we have been able to build our program from one which enrolled about 8 or 10 graduate students 6 or 7 years ago, to the point where today we have approximately 45 graduate students enrolled in this program.

These people that are being trained are going out and are helping to meet some of the needs, but we have to do a much better job of recruiting, we have to entice a great many more competent people to this field.

One of the things that I am encouraged by is the proposal which came out of one of the members of your committee, Congressman Elliott's 494 bill. It seems to me that takes a most intelligent approach to this particular problem because it gets right at the crux of the problem.

That is the providing of more hands, of more trained personnel, and it gets at that, I think, in a very effective way by providing financial inducement to training centers to set up programs in this area and also provides inducement to competent young people to come into the field.

One of the concerns that I have is that out of the work of this particular committee, I am sure that there is going to come some very, very fine things. I would hope that we would not have to wait too long before action could be taken on 494 because I think here we have identified a need in the area of common disorders, in the area of speech, in the area of the hearing handicapped.

We know what the needs are here. The needs are terrific.

We have in the United States today approximately 70 accredited training centers that are ready at this particular point to step up

their training programs when they get additional students or when they get the necessary financial resources to implement their programs. These are accredited schools.

We don't have the problem that we have in some other areas of special education, of deciding now what constitutes an accredited program or what constitutes certification, and so on.

These problems have been worked out in this field and I think that if 494 could be made into reality today it could go a long way toward meeting the needs of individuals with speech and hearing handicaps.

When we are meeting these particular needs we are meeting the needs not just of the individuals who have speech and hearing problems, but we are meeting the needs, part of the needs of the cerebral palsy individuals who have common disorders, we are meeting some of the needs of the mentally retarded who have common disorders.

So briefly, gentlemen, from the experience that I have had in the area of special education, from the contacts that I have had with professional organizations wrestling with these problems, I would see our crucial need here as that of a need for more personnel in the field.

I think the way to solve this particular problem, or, at least, one of the most effective ways of solving it is the procedure which has been suggested by Congressman Elliott in House Joint Resolution 494.

It is my hope and it is the hope of my professional colleagues from the State of Pennsylvania, that 494 will receive favorable action in the very, very near future so that the 70-odd training centers in this country who are prepared to train qualified people in speech pathology and audiology, can begin to get started on an expanded program so that we can begin to more adequately meet the needs we have in this field.

MR. DANIELS. Thank you, Mr. Matthews.

Do you desire to ask any questions?

MR. GLAIMO. On House Joint Resolution 494, I get the impression from you that there is great need for it and the whole country is waiting for the Federal Government to come in and participate with House Joint Resolution 494. What would happen if it were not to pass? What would the States do?

MR. MATTHEWS. As far as the State of Pennsylvania is concerned, and I cannot speak for the other States, I think some nice sounding words would be recited.

For example, we have had a Governor's commission that has done an excellent job trying to find the needs in the State. Actually, it has been doing on a small scale what your committee has been doing on the national scene.

But as far as implementing that in terms of providing funds, I am very, very pessimistic that anything would come out of this in our particular State at this particular time.

MR. GLAIMO. Then it is your feeling that unless the Federal Government passes something such as House Joint Resolution 494, it is very doubtful if there will be any progress in this much needed field; is that right?

MR. MATTHEWS. I would say that the progress would be very, very slight. For example, if an interested citizen in Pennsylvania is willing to give a scholarship to support one graduate student or United

Cerebral Palsy provides some money to train one or two people, or the Crippled Children's Society does the same sort of thing, this is a very, very slow process and extremely frustrating to those of us in the field who know if we had more hands we could help more people.

Mr. GIAIMO. Thank you.

Mr. DANIELS. Mr. Quie?

Mr. QUIE. Does this mean that it will be easier to convince the Congress of the United States of the need than the Legislature of the State of Pennsylvania?

Mr. MATTHEWS. Frankly, I would say yes. I think the history of social legislation in the last few years, particularly some of the measures that some of you gentlemen have been connected with, leads me to be more optimistic as far as the Federal Government is concerned, than my own State legislature at this particular time.

Mr. QUIE. I will say of the State of Minnesota Legislature that I think we have forged ahead in the last few years probably faster than the rest of the country.

Mr. MATTHEWS. Yes, particularly in the area of mental health, you have been leading the Nation.

Mr. QUIE. How many institutions will train speech pathologists and audiologists in the State of Pennsylvania—just the University of Pittsburgh?

Mr. MATTHEWS. No, at the present time there are graduate training programs at the University of Pittsburgh, University of Pennsylvania, Temple University, and Penn State University.

There are undergraduate training programs at approximately a half dozen smaller schools.

Mr. QUIE. In other words, a greater portion of the speech pathologists and audiologists are trained in Pennsylvania than, we will say, in the average State in the country?

Mr. MATTHEWS. Yes, than in the average State, but a much smaller number than would be trained in some of the Western and Midwestern States.

It happens that this is a field which developed to a large extent in the Midwest. I would say that at the present time your Big 10 universities are training more people at the graduate level in this field than any other group of schools.

In general, this is a field which has been later developing in the East than in the Midwest and Far West.

Mr. QUIE. You have no doubt but what schools in cities would make use of speech pathologists, provide for their salaries, if they were trained and ready?

Mr. MATTHEWS. I have no question about that. I have on my desk almost constantly, I would say today I have requests, I am conservative now, 50 different schools, colleges, community chest clinics, hospital clinics, and so on, writing in asking for personnel in this field and quoting salaries which are quite competitive.

We just don't have the people to supply.

Mr. QUIE. In the first part of this Resolution 494 it says:

Whereas each State cannot and should not undertake a wasteful duplication of facilities and faculties for the training of speech pathologists and audiologists. Now, therefore, be it—

and so on, with the great need of 20,000—where you only have 2,000—do you think there would be any duplication of facilities of the States?

Do you not think we need every bit of the facilities that now exist and perhaps even need to expand more for training speech pathologists?

Mr. MATTHEWS. It is possible. However, the expenditure to set up a really topflight training program can be pretty terrific.

For example, from your own State, the University of Minnesota has a very long and distinguished record in this field. Brinkleson was one of the first people in this country to establish a training program at Minnesota. There may be a couple other institutions throughout the State of Minnesota that would have either the interest or the total university facilities to go into the training in this particular area.

I would hate, for example, to see a dozen different schools in Minnesota go into this on a kind of halfhearted basis.

If I may illustrate what I think is bad, what I would not like to see happen, is what has happened, unfortunately, in a few instances growing out of last year's legislation in the area of mental retardation.

I think that was a bill that was passed to support the training of people for mental retardation, but unfortunately there were no safeguards in that bill to see to it that the people who were studying in this area went to school that had honest to goodness worthwhile programs.

So, as a result, in some places in the country individuals have selected schools to receive training in the area of mental retardation and they have selected schools which just were not ready to train them.

Mr. QUIE. You think the safeguards are in 494?

Mr. MATTHEWS. I think Congressman Elliott's bill has some very fine safeguards, inasmuch as it is written specifically in here that no school may receive grants in this particular area unless they have a training program which is approved by the national accrediting group.

I think that is a very fine idea.

Mr. QUIE. I think that is a good suggestion, that you bring up, because we did a study for 2 years in Minnesota and came to that conclusion, that rather than let State colleges get into this program of training the teachers for the handicapped, it ought to be centered in the University of Minnesota because you get a much better program that way.

Mr. DANIELS. Thank you very much, Mr. Matthews. If you have a prepared statement you desire to file, that statement will follow your oral testimony.

(The prepared statement follows:)

STATEMENT BY DR. JACK MATTHEWS, DR. HENRY GOEHL, AND DR. FRED KRAUSE
RE SERVICES FOR SPEECH HANDICAPPED CHILDREN IN WESTERN PENNSYLVANIA

PREVALENCE OF SPEECH PROBLEMS

Our committee has surveyed the prevalence of speech problems in the school-age population of Allegheny, Clarion, Green, Armstrong, Beaver, Washington, Westmoreland, Fayette, Lawrence, and Butler Counties. Our survey is based on data supplied by school officials as well as directors of speech clinics in hospitals, universities, and other agencies supplying speech correction services in the 10

counties. The survey shows that approximately 29,000 school-age children in these counties have been identified as having speech problems serious enough to interfere with their educational, social, and emotional adjustment. These data for western Pennsylvania are in essential agreement with prevalence data reported recently by the U.S. Office of Education. For a moment let us focus on the national scene.

Within the total population of handicapped children in the United States the largest group consists of children with speech and hearing disorders. More than one and a half million of our boys and girls have speech or hearing that is so seriously impaired that it can and frequently does interfere with their educational, social, and emotional adjustment. The most recent report issued by the U.S. Office of Education¹ estimates that 4 percent of our 40 million school-age population (5 to 17 years, inclusive) have severe speech and hearing handicaps.

If we take a typical city of 40,000 we would estimate the school-age (5 to 17 years, inclusive) population to be approximately 10,000. Table 1 (an adaptation of table 1 of the Johnson report cited above¹) presents the estimated number of these 10,000 school-age children with each type of speech and hearing impairment. Table 1 also contains estimates of the total number of school-age children in the country with each type of speech and hearing problem.

TABLE 1.—*Estimated number per 10,000, number in entire country, and percent of school-age children with each type of speech and hearing impairment*

Type of impairment	Number per 10,000 children	Number among 40,000,000 American children	Percent of children
Articulation problems.....	250	1,000,000	2.5
Voice problems.....	10	40,000	.1
Fluency and rate problems.....	5	20,000	.05
Stuttering.....	70	280,000	.7
Hearing problems of communicative and educational significance.....	50	200,000	.5
Speech problems associated with cleft palate and lip.....	5	20,000	.05
Retarded speech development.....	5	20,000	.05
Speech problems associated with cerebral palsy and other types of neuromuscular impairment.....	5	20,000	.05
Total.....	400	1,600,000	4.00

The estimates presented in table 1 are conservative and in each instance err on the side of underestimating the number of speech and hearing handicapped children. These estimates were based on Johnson's examination and evaluation of numerous surveys of the prevalence of impaired speech and hearing in children.

CRITIQUE OF EXISTING SERVICES FOR SPEECH HANDICAPPED CHILDREN

Returning to our 10-county area let us see what we are doing to help the 29,000 speech handicapped school-age children. Our study indicates that the 29,000 children are being treated by a staff of approximately 113. This means each speech clinician on the average is treating 256 children. This is three times the caseload recommended by experts in the field of speech correction.

The picture is even more distressing when we examine the qualifications of the individuals carrying on speech correction activities in the 10 counties. Only 20 of the 113 clinicians are certified by the American Speech and Hearing Association, the national professional organization in the field of speech correction. This means that 80 percent of the personnel working with our speech handicapped children in western Pennsylvania are not certified by the national professional organization of speech correctionists.

Additional weaknesses were uncovered in the area of early detection of speech problems. In the preschool population virtually nothing is being done to discover speech problems prior to entrance into school. Thorough diagnostic examinations are almost unavailable for most speech handicapped children in com-

¹ Johnson, Wendell, "Children With Speech and Hearing Impairment." Bulletin, 1959, No. 5, Office of Education, U.S. Department of Health, Education, and Welfare.

munities outside the Greater Pittsburgh area. Few of the 113 public school speech clinicians are trained sufficiently to carry out adequate speech diagnosis of the severely speech handicapped child. In this regard speech handicapped children in Pittsburgh and Allegheny County have an advantage over children in most of the other counties because of the larger number of well trained speech clinicians available in the school systems as well as in other agencies in the Greater Pittsburgh area.

Another great deficit in speech correction services is in classes for the mentally retarded and for the cerebral palsied. Approximately two-thirds of these children have speech problems, but only a small minority are receiving speech correction services.

CAUSES OF PROGRAM INADEQUACY

An important cause of the present lack of an adequate program for speech handicapped children is the shortage of trained speech clinicians. The shortage exists throughout the country. For the country as a whole a minimum of 20,000 speech and hearing clinicians are needed to meet the needs of our total speech and hearing handicapped population. At the moment we have available 2,000 certified and 5,000 noncertified personnel in this field.

In Pennsylvania the program is further hampered by regulations for State reimbursement which tend to encourage excessively large caseloads. Local districts seem to be tempted to present evidence of large numbers of speech-handicapped children being seen by speech clinicians in order to secure maximum reimbursement from State funds.

The present department of public instruction requirements for certification of public school speech therapists discourage many well-trained speech correctionists from going into public school speech correction and at the same time make it possible for individuals with a low level of qualifications in speech correction to obtain certification if they can present the certification requirements for classroom teaching. Pennsylvania certification requires the public school speech correctionist to be first a teacher and secondly to have a smattering of courses and training in speech correction. This is in direct contrast with certification procedures adopted by the city of Chicago with stresses training and competence in the field of speech correction with a minimum of required courses in general teacher preparation areas.

RECOMMENDATIONS

In view of the weaknesses revealed by our study we recommend:

1. The Governor be urged to ask all Pennsylvania Congressmen and Senators to lend their support to Senate Joint Resolution 127 (introduced by Senator Hill and others) and its companion resolution, House Joint Resolution 448 (introduced by Congressman Fogarty and others). This legislation would make funds available from the Department of Health, Education, and Welfare for the training of personnel in the speech and hearing field.

2. Steps to be taken to encourage the department of public instruction to re-define requirements for certification of speech correctionists, to place greater emphasis on competence in speech correction and less on competencies as a classroom teacher.

3. Regulations for State reimbursement to local school districts be drawn up in such a manner as to discourage the carrying of excessively large caseloads.

Mr. DANIELS. At this time I call James A. Kimple, superintendent of schools, Fair Lawn, N.J.

STATEMENT OF JAMES A. KIMPLE, SUPERINTENDENT OF SCHOOLS, FAIR LAWN PUBLIC SCHOOLS, FAIR LAWN, N.J.

Mr. KIMPLE. Mr. Chairman, members of the committee, I sincerely appreciate the opportunity of appearing before you this morning and since the committee has received much more expert testimony regarding the diagnosis and treatment of children needing special education than mine could ever be, and is completely aware of the magnitude of the problem, I shall confine my remarks to the community of Fair

Lawn and to our needs in special education and mental health as I see them.

Fair Lawn, as has many another community, has expanded rapidly during the past 15 years. With 7,700 children in school, we have now 5 times as many as we had in 1940.

During this time, as facilities and personnel have been added to accommodate increased enrollments we have not forgotten the physically and mentally handicapped nor the emotionally disturbed.

Ten years ago we employed our first school psychologists. Today we have six and are understaffed.

In 1950 we established the first special class for emotionally disturbed children.

Parenthetically, we shall never do this again. Today we have 4 classes for mentally retarded children with 32 of our own children and 17 who come from other districts.

We send four blind, six cerebral palsy, and two deaf children to other school districts.

We have 10 other children who are either institutionalized or would attend at private schools.

We also have two children currently at home with severe mental retardation who are receiving no training and two who receive home instruction on a regular basis.

I think this next statement is probably the most significant of all. Hence, out of 7,700 public school children, we have only 58 who we feel cannot receive adequate education through our regular school program when this is adjusted to the needs of each individual.

We obviously want as many of our children as possible, regardless of handicap, to be educated in our own community and to derive the benefits of close association with other children.

In my opinion, provision for the education of the handicapped is primarily a local responsibility. Since solutions to the problems of the handicapped depend to a very great extent on the attitudes of all people toward them, and this includes the emotionally disturbed, the handicapped person needs to be accepted by the nonhandicapped as human beings and as productive members of society.

Proper attitudes toward and complete acceptance of the handicapped can only be developed by close day-by-day association. That association is possible only within a local community.

This is why our classes for mentally retarded, both trainable and educable, are located in regular school buildings. The effects of this close association among the children, parents of normal and handicapped children, as well as teachers, have produced acceptance and understanding of mentally retarded that I would not have thought possible when we first established the classes.

This close association has had salutary effects on the attitude of education of normal children.

Our problem in Fair Lawn is primarily an economic one. We in conjunction with neighboring school districts need funds to help us do more than we are now able to do.

Parenthetically, next year we have budgeted for a class for blind retarded children within the school district and I think that this will be the first class of such a nature in the State of New Jersey.

In addition, we need a sheltered workshop for mentally retarded, a mental health clinic or an all-purpose clinic; facilities for special

classes in the immediate vicinity for cerebral palsy children, blind, cardiac, deaf; additional psychological services to help in the schools to do preventative work; additional speech therapists.

With these facilities and personnel we could go a long way toward the solution of our most pressing problems.

I should like to suggest that consideration be given to the provision of funds to local communities, either singly or in concert with each other, to do several things:

No. 1, to amortize the cost of classroom facilities and equipment, to help defray the expenses of local mental health or all-purpose clinics, and to provide for additional psychologists and speech therapists.

I would also like to suggest that these funds be made available to local communities on the basis of X number of dollars per pupil.

Mr. DANIELS. Thank you, Mr. Kimple.

Mr. KIMPLE. I might add, if I may, when we talk about the State of New Jersey, the State of New Jersey does provide a certain amount of assistance to local districts. For the mentally retarded classes we receive \$2,000 per class from the State.

We also, as the gentleman from Jersey City has said, receive transportation assistance, but this is the size of it from the State.

I might also say here that as far as the State of New Jersey is concerned, it is not carrying its full load for the education of all children. In Fair Lawn, for example, we receive about 13 percent of our total annual budget for educational purposes from the State sources.

Twenty-four percent comes from local tax on industry and the remainder from local property taxes.

It actually is quite a burden upon the local districts.

Mr. DANIELS. You mean real estate?

Mr. KEMPLE. Yes.

Mr. DANIELS. That is bearing the major burden?

Mr. KEMPLE. Yes.

Mr. DANIELS. Thank you.

Mr. QUIE. By annual cost of education, do you mean current expenses or the capital outlay as well?

Mr. KEMPLE. This is total expense. From the State we receive 13 percent of our total budget.

Of course, from the Federal Government we receive certain amounts, but this actually does not amount to anything that is significant.

Mr. QUIE. That \$2,000 per class for mentally retarded is a class grant?

Mr. KEMPLE. Yes.

Mr. QUIE. Is it the same amount for other handicapped classes?

Mr. KEMPLE. I think so, but I am not quite certain of this.

Mr. QUIE. Thank you very much.

Mr. KEMPLE. Thank you, Mr. Chairman.

Mr. DANIELS. I will now call Martin Mason as our next witness.

STATEMENT OF MARTIN MASON, BERGEN COUNTY CEREBRAL PALSY LEAGUE, INC.

Mr. MASON. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, I appear here today representing the Bergen County Cerebral Palsy League, an organization of parents and friends of the cerebral palsied, founded in 1948

and dedicated to the welfare and rehabilitation of the cerebral palsied and those with allied handicaps.

I have served the League since its start.

In speaking for the cerebral palsied, one must necessarily consider the blind, the deaf, and the mentally retarded, for all of these conditions may also be present in the cerebral palsied.

This statement will bear on the bill for independent living, H.R. 3465, on Joint Resolution 494, to provide teachers, speech pathologists and audiologists for those handicapped by deafness; on education, housing, and institutional care for the handicapped; on a census of the handicapped, and on tax relief for the handicapped and their families.

On the bill for independent living:

1. There are in Bergen County not fewer than 118—based on a tabulation prepared by the rehabilitation department of the Bergen County Tuberculosis and Health Association (see appendix 1) cerebral palsied individuals under the age of 16 for whom some, or all of the services proposed to be provided under this bill may be necessary.

2. There are in Bergen County not fewer than 800—based on a tabulation of children receiving service at Cerebral Palsy Center, Bergen County (see appendix II) cerebral palsied individuals under the age of 18, for whom some or all of the services proposed to be provided under this bill may become necessary as they reach employable age.

3. We, as parents and friends of the cerebral palsied, believe that the proposed bill will accomplish much for these handicapped. We are particularly interested on the provisions of title III, workshops and rehabilitation facilities, covering the establishment of nonprofit workshops for the severely handicapped.

On the joint resolution for help for individuals handicapped by deafness, we favor the passage of Joint Resolution 494, which will make available to children handicapped by deafness, including our cerebral palsied children so handicapped, the services of more specially trained teachers.

On education for the physically handicapped, Bergen County is a suburban area covering some 233 square miles. Within this area there are 70 municipalities with a population which has grown from 539,000 in 1950, to an estimated 800,000 today.

Some communities have provided special classes for the physically handicapped in accordance with the provisions of the Beadleston Act and will accept children from adjacent towns. These classes, held in plant suitable to the needs of the handicapped child and located in the near vicinity of the child's home represent the happiest solution of this problem.

There are, however, a number of towns which because of plant or other limitations, do not provide such classes, but avail themselves of facilities located out of the county.

One such facility which has accepted children from Bergen County is the A. Harry Moore School, in Jersey City.

Each local Bergen County board sending a child to the school pays for the transportation of the child to the school and for tuition at the school.

A recent survey indicates that not fewer than 53 are now being sent to the A. Harry Moore school. The cost of transporting

these children exceeds the cost of educating them; the wear and tear on the child is not inconsiderable.

We in Bergen County are grateful for the facilities provided by the A. Harry Moore school and hope that our children may continue to take advantage of them for as long as they may be available.

However, it would seem that a regional school located in Bergen County and specially planned to provide education to the handicapped is necessary for those who are physically and mentally within acceptable limits, but who are not included in any school program presently operating within the county.

The construction and administration of such a school would, however, require a community effort between the county and its 70 towns, and the support of the several public and private agencies working with and for the handicapped and in the field of education.

It does not fall within the responsibility of any single group or agency within the county or State to make the surveys required and to bring together all the components involved for a resolution of the problem.

The situation outlined above is certainly not singular to Bergen County. A solution to our particular problem would provide answers to similar problems throughout the United States.

It is therefore suggested that the Department of Health, Education, and Welfare, first, institute an investigation to determine what might be done to assist such localities in establishing proper facilities.

Second, institute a program of public education as to what Federal and State aid is available for such purposes.

On housing for the handicapped, we believe that no program of rehabilitation for independent living for the mentally regarded and severely physically handicapped can accomplish its purpose completely, without the provision of housing constructed or adapted to the needs of the handicapped.

It is suggested that the Department of Health, Education, and Welfare might institute a program of research to determine what may be done to provide such housing.

On separate institutional facilities for the mentally normal physically handicapped, there will undoubtedly be those for whom rehabilitation to the point of independent living will not be possible because of the extent of their physical incapacity.

We believe that institutional facilities for such individuals should be physically separate from those provided for the mentally retarded and for the aged.

On a census of the severely handicapped, in the development of any program for the handicapped it soon becomes apparent that no one knows within any reasonable degree of accuracy how many individuals will benefit from the program under consideration. Most programs under development are based on guesses, which are based on projections, which may be based on the number of individuals found to have a certain disability during the course of a basic research project. This is not a reflection on the value of any project, nor the factuality of the figures developed in connection therewith as they apply to that project.

However, there is reason to doubt that individuals selected for study represent a true cross section of the total number similarly handicapped.

Consequently, any projection of such figures may be seriously in error. It is suggested that, in keeping with our increasing concern for the handicapped, we count and catalog them so that we can better serve our society.

On tax relief for the handicapped, it has occurred to us that families charged with the responsibility for the care of a physically handicapped or mentally retarded child are under far heavier financial burdens than are those with normal children. In all equity it would appear reasonable that such families be granted an additional exemption which, together with the customary medical expense deduction, would to some degree compensate for and lighten that burden.

Further, it is suggested that individuals who are entitled to aid under H.R. 3465 and/or their families should receive like consideration.

It is suggested that such exemption be continued for as long as the family responsibility continues, or as long as the individual requires any of the services provided under H.R. 3465.

In connection with tax relief, it is suggested that the granting of the exemption be based on a doctor's certificate describing in brief the nature and extent of the disability. This information could then be turned over to the Department of Health, Education, and Welfare for dissemination to its agencies and affiliates.

In this way it is probable that all individuals entitled to such deduction would make application therefor, that the heavy expense of a separate census would be eliminated and that we would have the factual information on which our programs must be based.

Thank you for your courtesy and attention, and for your concern with our problems.

(The appendixes I and II, referred to, follow:)

APPENDIX I

There are in Bergen County not fewer than 165 cerebral palsied individuals over the age of 16 known to the rehabilitation service of the Bergen County Tuberculosis and Health Association.

Of this number 118 may require the further service offered by H.R. 3465, independent living bill. These individuals are presently disposed as follows:

Attending Clifton Cerebral Palsy Center.....	2
Attending private schools.....	2
Attending special classes in public schools.....	14
Attending A. Harry Moore School in Jersey City.....	4
Receiving home instruction.....	1
Attending the Easter Seal craft unit, Hackensack.....	15
Having no program at present.....	15
Too handicapped for services presently available.....	32
Looking for work (the severity of their handicap makes their employment problematical).....	11
In institutions.....	22

Of the balance 47 are situated at the present time, as follows:

In secondary school.....	23
In college.....	7
Employed.....	2
Have home businesses.....	8
Employed at Associated Craftsman (Sheltered Workshop).....	5
Married.....	2

APPENDIX II

Cerebral Palsy Center, Bergen County, Inc., Ridgewood, N.J.

Total admissions, between January 1950 and February 1960.....	930
Present ages of patients admitted between January 1950 and February 1960:	
Age 1 to 5 years.....	105
Age 6 to 10 years.....	365
Age 11 to 15 years.....	310
Age over 15 years.....	150
Total.....	930
Disability of patients admitted between January 1950 and February 1960:	
Motor disability.....	430
Retardation, blind, etc.....	140
Speech.....	360
Total.....	930
Multiple disabilities.....	270
Present disposition of patients admitted between January 1950 and February 1960:	
Special classes in 3 public schools.....	47
Special or retarded classes.....	140
Regular classes in public schools.....	425
State schools (institutions).....	51
At home, between 5 and 18 years:	
Retarded.....	51
Average.....	11
Total.....	62
Children under 5:	
Normal.....	5
At nursery school.....	26
Below nursery-school age.....	31
Retarded.....	21
Total.....	83
Deceased.....	16
Moved out of county.....	70
Over 18 years old.....	36
Total.....	930

Mr. DANIELS. Mrs. Marion C. Reed, president, Consumers League of New Jersey, Newark, N.J.

If you have a prepared statement, you may give a summary of it verbally. Following your verbal statement you may file your written statement for the record.

However, if you wish to read your statement you are at liberty to do so.

Inasmuch as we are running behind schedule, I must caution you, as I have the previous witnesses, to limit your time to a period of not more than 10 minutes.

STATEMENT OF MRS. MARION C. REED, WESTFIELD, N.J.,
PRESIDENT, CONSUMERS LEAGUE OF NEW JERSEY

Mrs. REED. Thank you. I will try to make it as briefly as possible. I will submit the statement and then give some oral testimony. (The statement referred to follows:)

STATEMENT OF MRS. MARION C. REED, CONSUMERS LEAGUE OF NEW JERSEY

My name is Mrs. Marion C. Reed. I live at 918 Boulevard, Westfield, N.J. I am president of the Consumers League of New Jersey.

This organization actively promotes fair labor standards, through investigation, education, and legislation.

ADDITIONAL FUNDS NEEDED

The New Jersey Rehabilitation Commission is making every effort to serve those disabled people who can be vocationally rehabilitated. More money is needed to care for all who require help. Five out of six handicapped persons must wait because the staff is too small to serve them. Each year of neglect makes the rehabilitation more difficult.

SOME THINGS CAN'T WAIT

Public health figures show that 7,810 persons in New Jersey become disabled each year. This past year 1,316 were rehabilitated. The current backlog is estimated to be 62,000. The staff is working to capacity.

Those rehabilitated last year will earn about \$3 million annually. This means increased purchasing power, plus a substantial tax contribution. It is stated by the rehabilitation commission that for every dollar spent on rehabilitation services, \$10 returns in taxes.

Experience proves that handicapped workers can learn to be dependable, safe, capable workers. Their "job" performance is even more satisfactory than that of the average worker who is not handicapped.

Without this chance, they may become hopeless, helpless financial burdens to the State or to their relatives. With this opportunity they can become a useful part of our productive economy.

This is not a plea for handouts. This is a plea for more funds to help those who want to work and enjoy a normal life.

H.R. 3465 SUPPORTED

We believe that the rehabilitation commission should service the disabled who can be improved to the point of self-care. The ability to take care of themselves would release needed hospital beds. It would ease the strain in many homes and in some cases would release a bread winner for work who, at this time, constantly attends the invalid.

The hope engendered in these forgotten men and women, by being able to take care of themselves, will propel many of them into part or full time employment.

HOUSE JOINT RESOLUTION 494 SUPPORTED

There is in New Jersey, as in other States, a shortage of trained speech pathologists and audiologists. This shortage can be partly overcome by making funds available to institutions qualified to give such training. The School for the Deaf in Trenton and the Day School in Newark, N.J., has a waiting list of children needing special schooling.

There is need for expansion facilities in these schools but there is a greater need for teachers. The best results are obtained by starting training early, but many children must wait.

One out of five children in the school systems of New Jersey has a speech defect. One out of about thirty-three children has a hearing defect and half of these children are permanently disabled.

One out of every ten of New Jersey's population has a speech problem. One out of every twenty has a hearing problem. It is estimated that 5 percent of adults over 15 years of age have hearing loss.

It is estimated that New Jersey has 2,500 aphasiacs (loss of the power to use or understand speech).

A research study of industrial deafness in New Jersey would be helpful in order to determine the extent of loss of hearing, caused by working conditions, and the preventive measures that are desirable.

Many having hearing disabilities have been serviced by the Rehabilitation Commission of New Jersey. In 1959 there were 140 accepted for service and 88 rehabilitated. Three case histories are:

CASE NO. 1

This 25-year-old single woman was referred by the New Jersey School for the Deaf. Although she had congenital deafness, she was capable of lipreading and use of sign language.

After a complete diagnostic workup, it was found that she was capable of undertaking college training and the commission sponsored a 5-year course, with a major in home economics at Gallaudet College for the Deaf. She graduated with high honors and made the "Who's Who."

The commission provided her with tuition, books and supplies, and partial maintenance. During the summer months she worked for a shirt company as a buttonhole operator, which gave her practical experience for teaching home economics, which was her vocational goal. Her earnings also supplemented the maintenance provided by the commission.

This case is particularly interesting in that she was finally placed at the New Jersey School for the Deaf in Trenton, which had originally referred her to the New Jersey Rehabilitation Commission.

Total cost to the commission, \$3,473.

This woman, who is now suitably employed, is also helping others with disabilities such as her own.

CASE NO. 2

Salesman rehabilitated

Charles R., age 59, was referred to the rehabilitation commission in April 1959. He had a diabetic condition, which was under control, and a serious loss of hearing acuity. Charles was self-employed as a salesman, dispensing household products door to door. His wife and 9-year-old daughter were dependent upon his income.

Since 1953 he has gradually experienced a loss-of-hearing acuity but was never financially able to purchase a hearing aid. During the past 2 years he experienced marked difficulty in maintaining a conversation. It became a frequent occurrence for him to request a repetition of phrases at home and with the public. In order not to appear disabled and foolish he pretended many times to hear. However, this proved frustrating in his work, as well as embarrassing and, as a result, he began to exhibit a serious degree of nervousness and insecurity. His approach to the public and his attitude toward work had begun a subtle change which threatened to affect his business.

An otiatric and audiometric evaluation arranged by his rehabilitation counselor disclosed the need for a hearing aid. His disability was diagnosed as bilateral impaired hearing, nerve degeneration, middle-ear disease, quiescent. With a hearing instrument, there was every possibility of resorting hearing acuity so that in the conduct of his business, the hearing difficulty now present could be removed. Provision was subsequently made for a suitable hearing aid and within a week after he had received this appliance he had learned to use the instrument with great success. He was able to enter into his work with greater self-confidence than before and sell to the public with increased effectiveness. Thus, not only was his job and income maintained, but his attitude, approach to the public, confidence in the future of his business, and ability to provide for his family was fully restored.

CASE NO. 3

This 39-year-old deaf man, married, with three children aged 15, 11, and 9, was referred by a municipal welfare department. At the time of referral he was suffering from anxiety which stemmed from his disability and had experienced friction at home and on the job. Because he was a poor manager, he had gotten into debt and a lien had been placed on his salary, which caused trouble

and disfavor with his employer, which ultimately caused loss of his job as maintenance man. He had moved from one town to another and his relief checks had been cut off by the former town because of some difficulties he had had with them. The referring welfare municipality, even though he had not acquired residency in their town, had undertaken maintenance of his family.

After general medical examination and a complete hearing evaluation, it was determined that the man could benefit by a hearing aid. This was provided and, after aptitude testing, it was decided that he was best suited for the kind of work that he had been doing. Through counseling and guidance this man gained enough confidence to apply for a job as a maintenance man with a board of education. As result of intercession of welfare worker and commission counselor, the client was hired.

The client, at present, is suitably and successfully employed as a maintenance man at a salary of \$250 a month, with which he is able to support his family. The emotional problems in a job situation and at home, which frequently accompanied the hearing loss, have been alleviated through the provision of the hearing aid and counseling and guidance.

This is a good illustration of agency cooperative relationships.

Cost to the commission, \$195.65.

This client had been receiving \$198 monthly from municipal welfare. He has now been taken off the relief rolls.

We urge that H.R. 3465 and House Joint Resolution 494 be enacted to provide money to increase the extent of this important work.

Mrs. REED. We believe that the Rehabilitation Commission of New Jersey has demonstrated the value of training those people who can be trained to be good workers. We are very loathe to say that we don't believe that they have covered all the people who should be covered, but it is because they haven't had the money to do it.

We hope that there will be more money for rehabilitating those people who can be employed. We support H.R. 3465, the independent living bill, because we believe that this is an area in which help should be given to make these people capable of taking care of themselves.

We also support the House Joint Resolution 494 because we know that there is a definite shortage of these specialized teachers in New Jersey.

The training school in Trenton, N.J., has a waiting list because they haven't enough qualified teachers. The day school in Newark also has a waiting list.

Some of this would mean expansion of facilities, but the greatest need is for trained teachers that are just not available.

We think that this resolution would help in that area.

I would like to speak also of the area of migrants which require special education. The migrant travels from State to State, as you know, and I believe it is an area in which Federal aid is needed to help out the State.

We have had three demonstration schools here in the summer for the children of migrant labor and have found that they have been very beneficial for those migrant children that could attend, but it only scratches the surface. There are many of them that cannot attend the schools.

The schools that we have had demonstrate the need for more summer schools for migrant children. Many of them are very far behind. Some of them have not attended school at all.

I think most of them are at least 2 years behind the grade that other school children would have.

Mr. DANIELS. Do you think that the migrant would send his children to school if more schools were available?

Mrs. REED. I am sure they would. They are very anxious for their children to have the opportunity that they have not had because they know that unskilled labor is drying up, that there is not going to be as much of it in the future as there is now and they are not educated well enough to go out and get work at other places.

They would like to have their children be able to get out of this stream that they are in.

Mr. DANIELS. I take it from your testimony the reason why they are not going to school is because there are not sufficient school facilities available at the present time.

Mrs. REED. Partly that. There are not enough summer schools available. These children move from one place to the other. It is very hard if you are in one place for 6 weeks to fit into a regular school system and get something out of it before you move on to the next.

It is understandable that some school districts are not putting forth a great deal of effort to get these children into the regular school because it means additional teachers; it means expanding the school system for a short period which is financially impossible for some of the districts.

I also would like to bring up the problem of the education for the migrant, himself, or herself. They have not received the education that most of the people in our country have received and they are thirsty for knowledge. They would like to have knowledge. I think that money could be used to use some of the facilities that we already have set up, for instance, the agricultural extension system, if there were someone there to go out to these migrants and help them for planning meals and how to take care of the house and a lot of things.

One migrant woman I spoke to and asked if she would like to have any kind of adult education, she said, "Oh, yes, I would."

I asked "What would you like?"

She said, "Anything. We just don't know anything. Just teach us anything. We would be so glad to know, anything that you could have us taught."

So I think there is a great need there. I think it could be done through the extension service. It could be done through the nutrition staff of the department of health.

I am suggesting these established agencies because I think if they are established it is always more economical to use them than it is to set up a completely new service for these people.

Mr. DANIELS. Does that complete your testimony?

Mrs. REED. Yes.

Mr. DANIELS. Do you have a prepared statement?

Mrs. REED. Yes, I had a prepared statement.

Mr. DANIELS. You may leave it with the reporter and it will be placed in the record.

Mrs. REED. Thank you.

Mr. DANIELS. I would like at this time to call on Mr. Herman Ehrlich, of the State of New Jersey.

Dr. BARNARD. I would like to request, on the part of Mr. Ehrlich, that his statement be made an official part of the record at this point.

Mr. DANIELS. Without objection, the statement of Mr. Ehrlich will form a part of the record.

(The statement referred to follows:)

PASSAIC, N.J., February 18, 1960.

The SUBCOMMITTEE ON SPECIAL EDUCATION,
Committee on Education and Labor, U.S. House of Representatives.

GENTLEMEN: I wish to express my most sincere appreciation for allowing me this opportunity to submit this report on behalf of the shut-ins.

I would like to explain the word "shut-ins" in the way I propose to use it in this report, I mean those people who are physically handicapped so that they find themselves unable to get out of their homes without help, but who with the help of door-to-door transportation and a place to meet with other similarly afflicted people to have a little recreational and social life, instead of just having to sit in their homes and watching that marvelous instrument, the television, or reading a book or newspaper, or doing some hobby or just having to look into space waiting that the day should pass.

I have a plan or the way I would like to call it, an idea, for a series of these places, or the way I would like to refer to them hereafter in this report, as a series of clubs that should be set up in almost every community in the United States where the people, which I have described above, could be brought or come there every so often, as often as possible, to pursue their hobby at their own pace, among people who will be willing to understand their problem and where there will be all kinds of help available, if they want it, to become a little more self-sustaining and to be able to take care of themselves a little better than they could do before.

These clubs would have to be staffed with competent personnel with funds provided by the Federal Government, and by the State governments and by local charitable groups as well as the members themselves through dues and other ways that could be worked out.

I am going to submit a more detailed statement regarding my plan for the above-described series of clubs as well as a letter from a former executive director of the Jewish Social Service Agency of Passaic, Clifton, and vicinity for 11 years in which he refers to the urgent need for a series of clubs as I have described above.

And now I would like to add a few words about the very important and necessary problem of providing the means by which handicapped persons can have the possibility of buying hospitalization-medical-surgical insurance, due to the very high cost of being ill today. It seems that the private insurance companies say that they cannot give us the necessary insurance because of the standards set for these policies. Therefore I think that here is an important field where the Federal Government could and should move successfully through the social security system of deductions.

Finally, I would like to say a few words about those of us receiving social security benefits from our parents' benefits. As you know I am one of these persons and I have been wondering for a long time, as to what happens when our parents are no longer here to help us out with what little financial aid they can. For example, I am receiving \$46 a month and I would appreciate it very much if you would tell me how am I going to live then. Therefore, I think that the Congress should look into this matter as soon as possible.

Hoping that you will be able to print these remarks and the accompanying material in full in the report of this hearing, I remain.

Very truly yours,

HERMAN EHELICH.

MY PLAN

I have a plan for a series of clubs for the physically handicapped who are homebound but are able to get out with help to attend meetings and to work on their hobbies as a help as occupational therapy and maybe a little physiotherapy and maybe any other activities as may be needed by the members.

The main purpose of these clubs will be to get these homebound people to also feel that they have a place where they are wanted and needed and maybe be helped some to be able to take care of themselves.

The purposes of these clubs will be both social and beneficial.

The social purposes will be—

1. To meet to exchange ideas.
2. To create better conditions for the physically handicapped.

The beneficial purposes will be—

1. To keep occupied while doing interesting hobbies.
2. To benefit from the programs of occupational therapy and physiotherapy under professional guidance.
3. To try to sell some of the hobby crafts that have been produced as well as to show the type of work that has been produced by the so-called hopeless.

I think that the best way the Congress could find out whether there is a need for such a series of clubs would be to use the files of such agencies as the social security offices and the rehabilitation agencies of each State.

Mr. DANIEL. I will call at this time on Mr. Joel R. Jacobsen, executive vice president and legislative director, New Jersey State Council.

Mr. Jacobsen, I welcome you here. I have noticed you have been out of the room for some time. I would like to say to you, as I have to the previous witnesses, that if you have a prepared statement and desire to summarize the views contained in that statement, you may do so, and that I must limit your testimony to a period not exceeding 10 minutes.

**STATEMENT OF JOEL R. JACOBSEN, EXECUTIVE VICE PRESIDENT
AND LEGISLATIVE DIRECTOR, NEW JERSEY STATE COUNCIL,
NEWARK, N.J.**

Mr. JACOBSEN. Thank you very much. We appreciate very much this opportunity to present the views of the CIO. I recognize fully that 10 minutes is impossible to delineate our total reaction to the legislation.

I would, therefore, like to confine myself to our general reaction with just one or two specifics which we would like to discuss in some detail.

First, the State CIO Council is in complete sympathy with the entire program. We support the independent living program, but we would commend to your attention a reservation which has been expressed by the National Federation of the Blind. This reservation appears to have considerable merit. We would call to your attention this particular reservation.

Secondly, we support the objectives of the Resolution 494. To be specific, however, I would like to concern myself with the status of the rehabilitation work in New Jersey and to indicate to the committee that as a government agency we could not ask for a more intelligent or a more responsive service than our present New Jersey Rehabilitation Commission.

The philosophy of that commission, the leadership of the commission, the personnel of the commission, in our opinion, could very well serve as a model throughout the Nation.

I emphasize that point because whatever deficiencies exist, they do not exist because of the philosophy of the leadership or the personnel, but there are deficiencies and these can be traced to the very vital phrase, "Lack of funds."

I know there will be presented to you later some statistics indicating the nature of the specific lack of funds and how it has adversely affected the work of the State.

It is an unfortunate situation in our State that we have a Government agency with the heart and mind to perform a vital function,

but it cannot succeed in assuming its total responsibility because there are not enough working bodies in which to place this heart and mind.

We would call attention to the fact that the present statute works as a ceiling to restrict the State appropriations for rehabilitation and we urge your consideration of this point.

Mr. DANIELS. You say the present statute. Is that the State statute?

Mr. JACOBSEN. The Federal statute.

Mr. DANIELS. In what area?

Mr. JACOBSEN. The formula works to restrict the appropriations from the State. It acts as a ceiling for the high income States.

We are further specifically concerned with the problem of the aging. If I can insert a personal parenthetical note, the way I feel this morning, this is not an academic subject in which I feel myself interested, but as medical science demonstrates increasing knowledge and progress obviously people live longer and as they live longer their problems are compounded and rehabilitation of the aged is a most vital subject.

In New Jersey 3 years ago the New Jersey Old-Age Study Commission published a report in which they set forth several items that might be worth repetition here. They stated for the general objective of shifting the emphasis on programs for the aging from custodial care in institutions to rehabilitation and return to community life, they quote the 1955 report to the Governor's Conference of the Council of State Governors as follows:

In the past a high proportion of persons with disabling chronic illness and handicaps have been relegated to custodial care in nursing homes, county homes, in homes for the aged, in their own families and even in general hospitals and chronic hospitals. It is now recognized that special provision must be made for those who can be rehabilitated.

This continues:

The objectives of geriatric rehabilitation includes restoration of the physically disabled patients to the highest possible degree of physical, psychological, and social efficiency, reintegration of the older person in the families and in the social groups in the community, and vocational retraining to enable him to return to employment.

We would commend to your attention this particular phrase.

I would like to emphasize and agree wholeheartedly with the statement entered by Mrs. Reed with regard to the education of the migrant. We have had a peculiar situation in the State where in the year 1959 we achieved a great social goal of making sure that the migrants had hot water which was certainly an achievement in this day and age.

I might add parenthetically that there has just been introduced in the State legislature a bill to repeal the hot water for the migrants.

As a symbol of the progress of the migrant it appears to us that these special education facilities are something that the committee would be very wise to consider.

We cannot understand the philosophy which keeps people in a depressed area because of lack of education and then prevents them from securing the education from which they could extricate themselves from the depressed position.

Mr. DANIELS. Thank you.

Do you have a prepared statement?

Mr. JACOBSEN. No, sir.

Mr. DANIELS. Thank you very much for your testimony.

I would like at this time to call Beatrice Holderman, director of New Jersey Rehabilitation Commission.

STATEMENT OF BEATRICE HOLDERMAN, DIRECTOR, NEW JERSEY REHABILITATION COMMISSION

Miss HOLDERMAN. Mr. Chairman and members of the committee, I appreciate the opportunity of appearing before you and can't commend too highly the work that you are doing in trying to uncover unmet needs as far as the human being is concerned, because there are a great many.

I do have a prepared statement that I would like to leave with you today, but I will try to confine this to the limited amount of time—I know you are behind schedule—and highlight some of the things that I think we would like to touch upon in New Jersey.

I am a relatively new director of the rehabilitation commission. I have just been in this position for 6 months, but I know in this time, and I have known this before, the great progress that has been made as far as the rehabilitation, vocational rehabilitation, of people is concerned.

I know also that some of this progress would never have been possible if the Federal Government had not led the way as far as the States are concerned, talking about a national level and about the State.

We know also, however, that there are grave unmet needs in our own legislation, and this is true all over. Vocational rehabilitation, as you know, is tied to the potential of employment. It is very difficult sometimes in our work when we see someone whom we cannot rehabilitate to employment status, to have to turn them away when you know possibly they might be helped if you could give them the kind of help that will be possible under the independent living bill.

Our board of commissioners of the rehabilitation commission wholeheartedly supports the principles embodied in this legislation.

We also support the resolution, 494, for speech and hearing, the development of speech and hearing specialist and greater training in this field.

We know that we do not have enough rehabilitation facilities in the State. We do not have enough sheltered workshops in many areas of the State to take care of the cerebral disabled.

This, again, means you are not able to give attention to the many people who need this work.

We are conscious of the fact that in many of the severe disabilities such as Parkinson disease, multiple sclerosis, multiple dystrophy, cerebral palsy, and epilepsy, that greater research would make possible help to the severely disabled people.

In the field of mental retardation, we know that in our own State a lot of good work has been done. We know, too, that we have only scratched the surface.

We do have an excellent cooperative arrangement with the Department of Education in going into the fields, but we are just beginning

in this field so that we can, with our own counsellor and the guidance counsel in the school, help to plan an objective for the child so that there is not the gap when the child comes from school into the employable or adult age.

One of the very grave needs in the State is trained specialists in the field of vocational rehabilitation, in vocational therapy, speech, and hearing therapists, and we cannot stress too highly how the Federal Government could help through grants to encourage the universities to include in their educational curriculums programs for training people who are needed if we are going to make any progress as far as helping the people who need it so badly.

Under H.R. 3465, citing several specific areas where you could illustrate the good that could be done through this bill, I am thinking of social security and the disability insurance.

We have through the Office of Vocational Rehabilitation a referral service for vocational rehabilitation of the applicant who may be eligible for rehabilitation. We know that probably in our own State roughly an estimate of a thousand people could be served and restored to independent status if it were possible to do the things that you want to do under this bill.

We know also in our geriatrics hospitals that many of these people could be helped.

To cite an illustration, Dr. Howard Rusk recently told a group in Princeton that they had made a study of the geriatrics hospital and of the 95 people used in this study, 90 of them should never have been in the hospital at all.

The term that these people had been there was anywhere from 400 days to 12 and 14 years. This is a waste, a human waste, not only from the standpoint of humanity, but also as far as our economy is concerned and certainly very costly from the standpoint of investment under this program.

You might be interested in a study that we did in rehabilitation in this past year, of 107 cases that had come to us from public assistance, the individual cost for rehabilitation was about \$695 as against public assistance cost of \$1,295 a year.

In our own State as you have heard our Commissioner and previous speakers tell you, we do not have the personnel to adequately develop the kind of program that we think is needed for the people of the State.

We have 38 counselors to service roughly 6 million people. You have 1 counselor serving a population coverage of about 145 people when the national average is about 75,000.

I think Mr. Jacobsen spoke about the ceiling. Under the present formula, and we wonder whether possibly this might discourage instead of encourage higher income States, we wonder if possibly a further examination of this formula would be good to ascertain whether there might be not the closed end on the Office of Vocational Rehabilitation appropriation, but an open end under some conditions. We certainly do not disagree with the formula. We think it is a very good formula.

I am very happy to have been here and I want to thank you for the opportunity to testify.

Mr. DANIELS. Thank you, Miss Holderman.

Are there any questions?

(The formal statement of Miss Holderman follows:)

STATEMENT BY BEATRICE HOLDERMAN, DIRECTOR OF NEW JERSEY REHABILITATION COMMISSION

As director of the New Jersey Rehabilitation Commission, I wish to commend the committee for its work in conducting workshops and hearings in order to discover unmet needs in the field of special education and rehabilitation and to analyze the adequacy of services now available. The opportunity afforded me to testify is sincerely appreciated. Accordingly, the following testimony is respectfully submitted:

Independent living, H.R. 3465 and H.R. 1119, Rehabilitation Act of 1959

Every year in New Jersey thousands of severely disabled men and women, with insufficient means, who could benefit from rehabilitation therapies are denied such help because they cannot qualify under the present vocational rehabilitation law. The existing law requires a reasonable expectancy of employment as a condition for provision of rehabilitation therapies. Because of this requirement, countless numbers of the most seriously afflicted find themselves doomed to a condition of homebound physical dependency or are bedridden institutional cases. Passage of the independent living bill making rehabilitation available to this "lost" segment of the handicapped population, especially in older age brackets and the chronically ill, would be a means of restoring these people to independent status. It would mean, in many cases, release from expensive institutional care, and result in tax savings. In other instances, such new-found physical independence would mean freedom from attendant care at home, thus affording normal family living.

The problem is a common one throughout the Nation, accentuated by the experience of social security disability insurance program which involves vast numbers of seriously disabled people for whom no help is presently available. A substantial number of these people who cannot be vocationally rehabilitated could be rehabilitated to a status of independent living. Professional counselors to supply the needs for the development of the independent living program will be needed. Federal funds would materially aid in their training.

The board of the New Jersey Rehabilitation Commission has endorsed the principles embodied in the H.R. 3465.

The potential humane and economic advantages of this legislation are extremely persuasive.

Rehabilitation of the aging

In view of the fact that medical science has prolonged the lifespan, problems in rehabilitation of aging have been intensified—particularly in the areas of medical care and employment.

Lack of understanding of this problem, together with virtually no application of rehabilitation procedures, often results in extended and expensive hospital and other custodial care. This was effectively illustrated by Dr. Howard A. Rusk in a recent address at the Institute on Psychology and Rehabilitation at Princeton, N.J. He stated that a study of 95 patients in a geriatric hospital revealed that only 7 were in need of continuing hospitalization and 2 of these were questionable, so that 90 of these patients didn't need to be in a hospital setting but were there because they had been forgotten or for social economic reasons. The average stay was a little over 400 days per patient and some had been in the hospital 12 and 14 years. This is one of the situations that might be overcome by passage of this independent living bill referred to previously.

It is an acknowledged fact that an individual over 45 years of age has difficulty in securing employment. As age alone does not necessarily reflect ability to perform effectively in competitive employment, this should be brought to the attention of employers through increased public information activities.

Restoration of section 4(a) (2) to Public Law 565 "Vocational Rehabilitation Amendments of 1954"

It was generally recognized that funds made available under this section, which expired after 3 years, had a profoundly beneficial effect upon the total program of rehabilitation.

Because there is still a lack of rehabilitation facilities in many areas of the State, it is not possible to serve all the severely disabled who could benefit by vocational rehabilitation services. Restoration of section 4(a) (2) would make

available additional grant funds and would tend to relieve this situation since private nonprofit organizations would be encouraged to develop and expand programs and facilities.

Increased grants to the U.S. Public Health Service for research in severe disability categories

There is still doubt about the vocational rehabilitation potential of disability groups such as Parkinson's disease, multiple sclerosis, muscular dystrophy, cerebral palsy, mental retardation, epilepsy and mental illness. Accordingly, it is urged that research in the above areas be encouraged in order to determine cause and remedial measures.

Scholarship aid for rehabilitation specialists, rehabilitation counselors and physical therapists

Since New Jersey has a pressing need for rehabilitation specialists, rehabilitation counselors, and physical therapists, and since training facilities for these disciplines do not exist within the State, it is recommended that the Federal Government assist in encouraging New Jersey institutions to institute these indicated programs through grants.

There is grave need for more trained people, not only in New Jersey but throughout the country, and encouragement should be given our educational institutions for adequate training.

Government subcontracts to sheltered workshops

Although sheltered workshops have demonstrated that they can produce effectively, they often have difficulty in securing subcontract work necessary for uninterrupted operation. It is, therefore, recommended that the Federal Government allot subcontracts to facilities serving the severely disabled such as those affected with Parkinson's disease, multiple sclerosis, muscular dystrophy, cerebral palsy, mental retardation, epilepsy, and mental illness.

House Joint Resolution 494

To meet the urgent need for specially trained teachers of the deaf, speech pathologists and audiologists, passage of the above resolution is recommended.

The need is quite evident when an estimate in New Jersey indicates: 20 to 23 percent of the students have speech defects, 3 percent have a hearing problem (a survey in the schools developed this information).

Five percent of the adult population over 15 years of age has a hearing loss. Universally, 10 percent of the people have a speech problem.

Statistics

It is recommended that statistics on the national level be developed on the disability group and older workers which, when translated, will enable the States to plan and direct programs that will result in more and improved services where most needed. It is further recommended that Federal personnel assist the State agency in developing and expanding meaningful statistics, through both consultative and financial aid.

Funds

Essential to any program affecting the general welfare and economy of the State and Nation are sufficient funds for both personnel and case services so that assistance may be given to all persons in need of vocational rehabilitation. At the present time, budgetary limitations permit the New Jersey Rehabilitation Commission to employ a total of 38 counselors and 6 district supervisors. Accordingly, the population area served by each counselor is 148,000. This situation exists despite the fact that a recent OVR survey recommended an increase in counseling staff to 75 and district supervisory staff to 10. This would have the effect of reducing the population served by each counselor to 75,000 and would bring New Jersey's counselor-population ratio in line with that recommended by the OVR. The commission is only able to rehabilitate about one-sixth of the 7,810 persons who are disabled and will come to need vocational rehabilitation each year, with a growing backlog not being served.

The present Federal grant formula has an adverse effect on high income States such as New Jersey where it works as a ceiling rather than as a statement to higher State appropriations.

I recommend that the formula be intensively studied with a view toward evaluation of the advisability of discontinuing the "closed end" OVR appropriation.

Mr. DANIELS. At this time I would like to acknowledge the presence in the audience of two of our very distinguished citizens of the community. Sheriff William J. Flanagan. We are indeed grateful to you, Sheriff, for making the facilities of this beautiful chamber available to the congressional committee.

Sheriff FLANAGAN. We are very happy to have you and the committee.

Mr. DANIELS. Seated alongside of Sheriff Flanagan is the Honorable Louis J. Messano, secretary of the Jersey City Board of Education.

Mr. MESSANO. Thank you, Mr. Congressman.

Mr. DANIELS. We will adjourn at 12:30, so I think we will have the opportunity of calling a few more witnesses.

At this time I would like to call Mrs. Betty B. Hahle, president, National Organization for Mentally Ill Children, south Jersey chapter, Riverton, N.J.

STATEMENT OF DR. IVA MINTZ, CHAIRMAN OF THE BOARD OF DIRECTORS, SOUTH JERSEY CHAPTER, NATIONAL ORGANIZATION FOR MENTALLY ILL CHILDREN

Dr. MINTZ. My name is Dr. Iva Mintz. I am the coordinator of clinical services at Glassborough State College.

I am here representing Mrs. Hahle.

My affiliation with the National Organization for Mentally Ill Children is that of chairman of the board of directors of the south Jersey chapter. I am here representing the three State chapters, northern New Jersey chapter, and Union County chapter.

Mr. DANIELS. With the admonition that I gave to the other witnesses, will you try to keep within the time limitation, sir?

Dr. MINTZ. I will try to.

I am also, if I may, I was scheduled to appear tomorrow as an individual.

I have sent a letter to your subcommittee saying that I will not appear tomorrow and that my testimony will be included with the testimony of today, so the 10 minutes will be saved tomorrow.

Mr. DANIELS. Fine; you may proceed.

Dr. MINTZ. Attempting to outline the most urgent needs in special education and rehabilitation for mentally ill and emotionally disturbed children sharply focuses attention on the tragic plight of the largest single group among the Nation's most neglected handicapped and afflicted children.

There is virtually a total lack of special programing for these boys and girls.

While the problems of these children has been recognized for a relatively short time, and while we still have insufficient knowledge concerning the causes and cure of mental illness, still, enough work has been done by responsible professional people to justify setting up constructive programs and expanding research.

Public support is difficult to obtain, since mental illness is neither fatal nor physically crippling, and, therefore, lacks the emotional appeal of other disabilities, and fear of stigma still makes many

parents reluctant to identify themselves as parents of mentally ill children.

Dr. Lauretta Bender, has written :

We have not found that these emotionally disturbed, atypically developed schizophrenic children come from any special type or kind of home or parents. They come equally from homes of intelligent, sophisticated, economically secure parents, and from the unintelligent, naive, and underprivileged social classes. They come from concerned, cooperative, two-parent families and from grossly deviate, antisocial, abandoning parents. Some parents have grown emotionally in their efforts to meet their children's needs and are articulate about their problems, other parents have met failure with depression and psychotic breakdowns * * *.

Most public schools exclude the seriously disturbed child; private schools are costly. The effect of this frustration in finding help creates growing tension in the family, and inevitably is communicated to the troubled child.

Other children in the family are caught up in a chain reaction as they become aware of family tensions, the attitude of neighbors, and the constant demands on their parents by the sick child.

We must provide an educational program which will help the community accept the mentally ill child as a sick child, and assume responsibility for his care.

For the child who needs a controlled environment away from home, the entire State of New Jersey has but two residential treatment centers and the waiting lists for admission are long.

The only alternative for those who can neither find nor afford placement is the State hospital, where humane care can be found.

Little can be done about returning the child to his family and community without provisions for education, vocational, and therapeutic program directed to that end.

If it is our objective to help the child to return to a more normal atmosphere, then we must accept the the necessity of keeping the residential center physically within the community and of providing a program that will be constructive and continuing.

There is an overwhelming need for facilities to help children who have had residential care to make the transition back to neighborhood, and to stay there. Day care centers, if available, could right now remove a considerable number of children and sheltered workshops for teenage mentally ill children could help them to become accepted and useful young adults.

Seriously disturbed children once considered uneducable can be helped socially and educationally in an environment suited to their needs.

The Forum School in Paterson, organized, and maintained by the northern New Jersey chapter, of NOMIC, since 1954, has gained a widespread reputation as a pilot school demonstrating this. This day school is currently working with 20 children from 5 to 12 years of age. They are all seriously disturbed and would, in the absence of this school, either vegetate at home or be institutionalized.

Such a school requires an extraordinarily low pupil-teacher ratio. Most essential is an atmosphere free from tension, in which a child is accepted unconditionally for what he is, and not for what we would like him to be; where deviation will be tolerated, and he will be helped in his attempt to work out his own problem.

The program must be flexible enough to allow the teacher to take advantage of the child's interest at the moment, since academic training can be given only as he shows capability and readiness for it. We must first of all reach, then teach, the child.

Because of the importance of the teacher-child relationship, academic achievement is not the paramount requisite for teachers in such a school. Stability, affection, warmth, and, above all, sincerity, these are musts for teachers of mentally ill children.

Progress is slow and irregular, yet at the Forum School it is encouraging. A small percentage of children have even been able to return to the public schools in their own communities and to do well.

In theory we recognize the right of every child to an education suited to his needs. Physically handicapped and mentally retarded children are provided for in our educational systems, and with the passage of the Beadleston law A-125, New Jersey has become the second State in the Nation to expand its program to include help for the moderately disturbed children in schools.

Early recognition, with a sound program planned and carried out, can substantially reduce the burden, to the children themselves, and to society, that will develop if they are left to stumble along until, as young adults, more serious problems send them to institutions for care.

The expense of implementing such a program is considerable, but it is not too much when compared with the cost of teacher hours lost in every classroom today because time needed for, or distractions caused by, children who are suffering problems of emotional disturbance or social maladjustments; or when compared to the cost of life-long care.

The benefits of raising the mental health level for the average child and regular classroom teacher must not be overlooked.

A community program is needed, but to obtain it, today's attitudes must first be changed. Propaganda is not enough. When we demonstrate that something can be done for these children, attitudes will gradually change. Communities must be encouraged by the State, as in turn the State must be encouraged by the Federal Government.

We must begin now, before another generation of troubled children become the mentally ill adults of tomorrow.

There is a growing awareness of the problem of finding trained personnel to work in specialized centers.

It is the experience within the pilot study programs of NOMIC that people are interested in finding opportunities to work with seriously disturbed children, and are seeking training programs toward that end. A most practical way to encourage competent workers to enter the field is to provide opportunities for training, and to make them aware of the existence of enough facilities to make the training realistic preparation for employment.

New Jersey's teacher-training programs are only now beginning to conceptualize curriculum at a graduate level for teachers to work with mentally ill children. Such a curriculum, yet to be developed, should include educational methodology and content as well as courses in normal childhood development and psychopathology in children.

Further, it should include orientation and preparation for collaborative work with allied disciplines such as psychiatry, psychology, social work, pediatrics, and neurology.

Graduate training of this kind should further include supervised fieldwork or supervised training in specific facilities that are directly working with mentally ill children.

Federal support and encouragement of such training programs is imperative, since State departments of education find it very difficult, if not impossible, to develop and expand regular teacher-training programs through presently existing facilities and faculties.

Any facility that renders direct service to mentally ill children on a day or inpatient basis needs to provide ongoing supervision and inservice training to such teachers, making them part of the working team of experts.

There is considerable variation and looseness in the amount and kind of inservice training now taking place in facilities rendering direct treatment and educational service to mentally ill children.

In New Jersey, the State commission on mental health is working toward raising of standards in care, treatment, and education of mentally ill children.

We believe that the Federal and State Governments should work cooperatively in this particularly:

A. In State hospitals, with special attention to mentally ill adolescents—vocational guidance and vocational training;

B. In the provision of halfway houses, or transitional day treatment facilities for children ready for discharge from inpatient facilities, charged with responsibility of accepting State hospital patients.

Helping services to child and family, to protect previous therapeutic investments and to maximize the child's ability to assume a limited, though productive, role in society must include:

A. Sheltered workshops.

B. Protected employment.

C. Full scale education programs to convince industry to accept mentally ill young people in employment.

D. Social and psychological service for the child and family, so as to support and enable the child or young adult to take, and to maintain, his place in community living.

A structure for this might be developed by expanding the scope and services of presently existing county and community guidance centers.

Legislation should be so designed that counties with low population levels can obtain the financial aid that they need to develop and maintain a program of special education and rehabilitation, for a matching fund type of plan in an area with extremely limited resources cannot hope to ever secure enough funds to do so otherwise.

We need both Federal and State financial aid to develop community sponsored and perpetuated programs, given in such a way that funds will be used for the specific purpose of aiding mentally ill and emotionally disturbed children, and not rechanneled into other categories.

Local school districts must be educated to the value of the program, and encouraged to do their part in developing and maintaining such a program.

We recommend that a stipulated amount of money be designated to setting up the child study teams as provided in A125 in order that the children in New Jersey's public schools may benefit as soon as possible from the services provided therein.

Day hospitals and day treatment centers with public school teachers, or Federal or State payment for teachers at these institutions, could reduce financial and human costs of hospitalization and of ever growing waiting lists.

In the entire field of special education, as in regular education, the States will need the encouragement of appropriate and meaningful action.

Therefore, we urge that the Federal Government accept the responsibility of providing special training programs for the professional preparation of leadership personnel in the education of emotionally disturbed and mentally ill children, through fellowship programs and/or providing leadership to those institutions involved in the training of teachers whereby a comprehensive national program of training of leadership personnel for education in this specialized area is undertaken in every State in the Union.

We suggest that the Federal Government should further assume responsibility in collecting data from independent, public, and voluntary agencies now rendering inservice training to teachers to develop a body of knowledge pertaining to the ingredients of such training and to augment any Federal program designed toward this end.

We feel that bill H.R. 3465 would provide a much needed service among handicapped persons and we would like to go on record in support of it.

We are glad the term "mentally handicapped" as used throughout the bill, includes mentally ill and emotionally disturbed persons.

We are encouraged by the rising interest and concern about the many urgent and pressing needs of mentally ill children, and are grateful that this committee is sincerely trying to do something about so important a part of those needs as special education and rehabilitation.

Mr. DANIELS. Thank you very much, Dr. Mintz. I am sorry to put a little pressure on, but we are running an hour behind schedule and people have traveled quite extensively to come here today.

We would like to hear the testimony of all of these witnesses who have been good enough to travel from afar to give us the benefit of their views.

Now, we will only have time to call one more witness and then we will adjourn for lunch.

At this time I desire to call George F. Meyer, executive director of the New Jersey Commission for the Blind.

**STATEMENT OF GEORGE F. MEYER, EXECUTIVE DIRECTOR,
COMMISSION FOR THE BLIND, NEWARK, N.J.**

Mr. MEYER. Thank you.

Mr. DANIELS. Mr. Meyer, you know of the limitation of time that we must place on your testimony.

I do trust that you will be able to give your statement to us.

Mr. MEYER. You give me the bell, will you?

Mr. DANIELS. All right.

Mr. MEYER. Because I know these people are hungry.

Mr. DANIELS. You may proceed, sir.

Mr. MEYER. I am appearing before the committee here and I appreciate the privilege of coming here primarily at the invitation of the

committee, because I have participated in one or two groups that have prepared material for the committee and I am taking advantage of this opportunity to stress a point of view in connection with certain aspects that would not normally be included in such recommendations coming from groups.

First of all, I want to say that New Jersey is really quite proud of its program for the blind because it is one of the very few States, almost the only State, where all of the work is incorporated in one organization, which, of course, has a great many advantages from the standpoint of coordinating one program with another and taking advantage of economies that come from the consolidation of the work.

Furthermore, I feel it has been a great privilege to work in four different States, Minnesota, Washington, Ohio, and New Jersey, and also to have worked in the area of education and in the area of administration and rehabilitation.

To begin with, let me say that in reference to Resolution 494 I think it is a marvelous thing to think that we are taking these steps. I hope that features in behalf of the blind can be included in it.

I think there may not be quite the same need for teachers of the blind, to provide facilities for teachers of the blind, because in so many cases teachers learn on the job to take care of the needs of blind people.

But I think that is also a weakness. If we look at the two or three thousand teachers who are employed teaching blind children, we find a great many that are not fully qualified and we find that States are extending themselves in order to get well-qualified teachers.

We in New Jersey have drawn upon the interest of socially minded people to make graduate studies possible for likely candidates for teaching in our schools.

I would like to add one caution, however, and that is that I think any individual who receives a compensation for taking these courses ought in some manner to be psychologically, at least, bound to render service in that connection. I say that because that is not true of some of the existing programs.

People are sometimes sent to take advantage of the training and then have no obligation to perform the services in the field.

With reference to H.R. 3465, I think it is also an excellent bill. I think that we have to give some consideration to the control of workshops that are authorized in it because experience has shown that without perhaps always intending to do so, the conduct of workshops conducted under private auspices is an undue drain upon the facilities of the community, the charity of the community; they are sometimes competitive one with another, their standards are not at all uniform and in other respects they deserve to be reviewed for the best interests of all concerned.

That is particularly true in light of the fact that we are here in this building encouraging the organization of many more of this type of service to handicapped people.

Now, the nature of work, of our work in New Jersey, where it is all coordinated, has emphasized to me something that I think has been a problem to both the Federal and the State Governments and that is the distribution of activities for the blind on the Federal level among some 29 different agencies.

Now, it is extremely different for State agencies for the blind, or State agencies, I may say in general, to ascertain the services that are available in all of these sections of government and rather than elaborate upon the entire problem it seems to me that it would be a very constructive thing if some action could be taken on the Federal level by which there would be at least a single high level coordinator who would be an authority on what is available in these separate activities.

Mr. Crampton tells me they are issuing a book of 600 pages telling what is available in these 29 different agencies, but it takes an awful lot of time to read a 600-page book and there are not many people who are going to take the trouble to read it.

I think we need, furthermore, a specific interpretation of some of these services so that they may be correlated one with another and also with the facilities within the State.

The relationship between the independent living bill under rehabilitation and its execution under the assistance program is something I think that ought to give us pause because the objectives are completely different.

One of the things that concerns me is the fact that agencies for the blind are precisely in the middle of the whole situation because they have candidates in both fields and, therefore, we always have experience in the handling of blind people in their homes.

The thing I would plead for is that any services that are extended to blind people in any one of these programs, automatically they would be extended through the rehabilitation program anyhow, but if they are extended to the assistance program that should be coordinated with the services to the blind because they are the one agency that knows what blind people need.

Mr. DANIELS. I was just about to sound the bell to advise you that you had about 2 more minutes to go.

Mr. MEYERS. Then I would put stress on something that was brought up here and will undoubtedly be brought up again on the needs of multihandicapped blind children. More and more we are finding that blind children come to us with brain injuries, with emotional disturbances, and various other types of handicaps that combined with blindness cause a situation that is very, very difficult to meet.

We have on our educational program a policy of gearing the program of education to the need of the child and in some of these instances we find that the treatment that the child needs may run as high as five and six thousand dollars a year in order to put him into a position of profiting from his education. That is a cost that we are not in a position to meet.

Mr. DANIELS. Does the child get that directly from the New Jersey Commission for the Blind?

Mr. MEYERS. Normally he would.

Mr. DANIELS. How about the local school system?

Mr. MEYERS. Actually the New Jersey Commission for the Blind draws together the facilities of the local school system and residential schools and our own staff. We have a staff of 20 teachers that coordinate with the public school system to take care of some 600 blind children right in the public schools as your child goes to the public schools.

Then, of course, we have some 80 or 90 children that we send to residential schools. Of course, within the State also we have some 150 children that attend the schools that you have heard about in Jersey City here, for the partially sighted.

There is one more point I would like to make. That is that we become so enamored with our idea of programs that we sometimes lose sight of the purpose of all of the programs. I am thinking particularly of the matter of sight restoration. We have no program of sight restoration and the program of sight restoration varies from State to State.

It is surprising how many people are not able to get the service that they need for sight restoration.

Now, from an economic standpoint, I am sure you can appreciate the fact that if you restore the vision of a child of 5, you have saved a good many thousand dollars in his education and you have saved a good many more thousand dollars in the field of assistance or rehabilitation, yet there is no provision made for that kind of service.

We have to wait until he gets his education and comes up to the age of 21 or 18, before we have the finances available through Federal contributions to make an operation available to him.

Now, thank God, of course, some of the States provide that out of their own funds, but that is not done universally and we ought to look to see that that kind of service, physical restoration, particularly sight restoration, becomes available to the people at the earliest age to the benefit of everybody.

I want to say just a word on housing. We make a provision for public housing for people who have low incomes and, of course, many, many blind people have low incomes. Most of them have. Yet the competition that we have in the urban sections for the public housing that is available pushes out the people who sometimes deserve it most, such as the handicapped, the aged, and the blind.

It seems to me that it is only fair that some provision be made by which a quota system would be set up so that they might have at least a toe in the door to get a chance at some of these low-priced housings that are available.

Thank you.

Mr. DANIELS. Thank you very kindly for your testimony. It has been most helpful and beneficial to the committee. We appreciate your coming here today.

Mr. MEYERS. Thank you.

Mr. DANIELS. Now we will adjourn and return here at 1:45 to continue with the hearings this afternoon.

We are running about an hour behind schedule. I do hope that this afternoon we can make up that lost time.

The first witness this afternoon will be Joseph Feinman.

(Thereupon, at 12:40 p.m., the subcommittee was recessed, to reconvene at 1:45 p.m., same day.)

AFTERNOON SESSION

The subcommittee reconvened at 1:45 p.m., upon the expiration of the recess.

Mr. ELLIOTT. The subcommittee will be in order.

In our absence two ladies who were invited to testify tomorrow, namely, Mrs. Kitty Shinton and Mrs. Sheridan, have filed statements for our record. They will not be present to testify orally.

Without objection, those two statements will be made a part of the record.

(The statements referred to follow:)

FEBRUARY 18, 1960.

DEAR SIR: As parents of deaf children, we are writing to ask your help in securing the passage of Senate Joint Resolution 127.

This legislation is designed to help alleviate the national shortage of classroom teachers of deaf children, speech pathologists, and audiologists through scholarships and grants to training centers.

As parents of deaf children we are particularly concerned with the teacher shortage. The Department of Health, Education, and Welfare states that the greatest teacher shortage exists in this area of exceptionality. Approximately 500 additional teachers are needed for next fall, and training centers have turned out only 125 this year.

As parents we are vitally concerned that our children not be denied educational opportunity because of the teacher shortage. There are some 30,000 deaf children of school age whose parents are anxiously concerned about the increasingly desperate shortage. With proper education we can expect that our children will grow up to be useful, productive citizens. Over the past 10 years, enrollment of deaf children in schools for the deaf has increased about 400 per year. Last year the increase was 900.

Providing trained teachers of the deaf must become a Federal concern because individual States have no training facilities. There are 22 accredited training centers in this country. With additional funds they could provide a substantially greater number of teachers.

Organizations which have united to secure the passage of the proposed legislation are the Alexander Graham Bell Association for the Deaf, the Conference of Executives of American Schools for the Deaf, the Convention of American Instructors of the Deaf, and the parents' section of the Alexander Graham Bell Association.

We would appreciate your support of this legislation.

Sincerely yours,

Mrs. KITTY SHINTON.

PHILADELPHIA, PA.

FEBRUARY 18, 1960.

HON. CARL ELLIOTT,
Chairman, Subcommittee on Special Education.

HONORABLE DEAR SIR: One of the most serious problems in the field of education is in the field of the education of the deaf, especially the great shortage of trained teachers. We would like to submit the following suggestions:

A definite plan for training teachers for the deaf must consist of a combined program of a university or college and a school for the deaf. Philadelphia cannot boast of this, the fourth largest city in the Nation.

Two outstanding programs of this type are at the Clerke School, Northampton, Mass., and the Central Institute, St. Louis, Mo. Even these two programs could be expanded and improved upon with Federal funds. Such programs should be established throughout the eastern Atlantic region, where there are many universities and colleges, as well as schools for the deaf. Funds should be made available to qualified students desiring to become teachers of the deaf.

Federal funds should be used to boost the salaries of these teachers. In Philadelphia the salaries of the teachers for the deaf are below standards. This is a very grave and embarrassing situation and not until we have properly trained and adequately paid teachers will the education for the deaf not be considered one of the most neglected segments of education.

Very truly yours,

Mrs. KITTY SHINTON,

Mrs. REGINA H. SHERIDAN,

Parents of the Deaf.

Mr. ELLIOTT. Mrs. John M. Alton, president of the New Jersey State Federation of Women's Clubs, wires that an accident prevents

her from appearing this afternoon, but that she will send a statement for the record.

Without objection, that telegram also will be made a part of the record.

(The telegram referred to follows:)

ATLANTIC CITY, N.J., February 18, 1960.

Congressman CARL ELLIOTT,
Chairman, Subcommittee on Special Education, Assembly Chambers, Hudson
Administration Building, Jersey City, N.J.:

Regret accident prevents appearing this afternoon. Will send statement.

Mrs. JOHN M. ALTON,
President, New Jersey State Federation of Women's Clubs.

Mr. ELLIOTT. Our next witness is Mr. Joseph Feinman of the New Jersey Association for Retarded Children, of Trenton, N.J.

Is Mr. Feinman here?

Mr. Feinman, may I say to you that we are running a bit behind time and, as much as I regret to do so, I must impose a time limitation of 10 minutes upon your testimony.

You use that 10 minutes in any way you see fit. If you have a written statement, it will be made a part of the record, if you desire, following your oral remarks.

Now, you may proceed.

STATEMENT OF JOSEPH FEINMAN, NEW JERSEY ASSOCIATION FOR RETARDED CHILDREN, TRENTON, N.J.

Mr. FEINMAN. Mr. Chairman, honorable members of the Subcommittee on Special Education of the U.S. House of Representatives on Education and Labor, I am an attorney of this State. I appear not in that capacity, but on behalf of the New Jersey Association for Retarded Children, a nonprofit statewide organization of some 2,500 members, most of whom are parents of a mentally retarded child.

I, too, am a parent of a mentally retarded child.

Mr. Chairman, the tremendous postwar population growth of New Jersey, the heavy concentration in this State of military bases with an unusually large number of military transients in training, and the enactment in New Jersey of the Beadleston Act, which guarantees education and training to the educable and trainable mentally retarded, these have all resulted in a need for teachers trained to teach the mentally retarded.

The most urgent need in New Jersey today in the field of special education for the mentally retarded is a critical shortage of trained teachers.

This critical need has been known to the Congress which enacted legislation designed to provide a flow of such trained teachers.

Under the National Defense Education Act, grants are provided to colleges and universities for fellowships to graduate students and, since the enactment of this law, one set of fellowships in the field of special education has been awarded by the Office of Education to Wayne University.

Under Public Law 85-926, grants are also provided to colleges and universities for such fellowships, as well as further grants to State departments of education for fellowships and scholarships to those who desire to enter the field of teaching the mentally retarded.

The congressional intent is to be applauded. The result, to date, however, has been a mere trickle of trained teachers, and the critical need for such teachers continues to exist and becomes more critical from day to day.

Mr. ELLIOTT. May I ask the gentlemen, is not the reason for that the fact that we were late about getting the appropriation made under the bill to which he refers, to train teachers for the mentally retarded?

My recollection is that we passed that bill on the last legislative day of the 2d session of the 85th Congress, sometime in August or September 1958. Then for that year we did not have an appropriation because we did not pass the bill soon enough to get an appropriation that year.

So our first appropriation under that bill came about midway of 1959, which means that we are now in the midst of about the first school year under that bill. Is that not the reason for apparently being so long and slow getting started?

Mr. FEINMAN. I think, Congressman Elliott, that is only part of the reason.

Mr. ELLIOTT. We did appropriate a million dollars to start that teaching program, it is my recollection.

Mr. FEINMAN. As my presentation will exhibit, the reason, as we see it, is that not enough money has been appropriated and, therefore, only a trickle will ever come out. The pump has to be primed.

To properly implement the intention of Congress, the New Jersey Association for Retarded Children recommends that much larger sums of money be appropriated so as to multiply the output of trained teachers.

The laws adopted by Congress to date, to fill this acknowledged void, have been both long range and short range in nature. Implementations, however, have been short range only.

Under Public Law 85-926, the Office of Education has acted in the direction of providing trained teachers as quickly as possible, and although Public Law 85-926 provides for Federal grants to colleges and universities to help underwrite programs for training of teachers of the mentally retarded, i.e., creation of a faculty of special education, nevertheless the Office of Education has been unable to do anything in this direction. Whether because of lack of funds, or because of the lack of a direct congressional mandate, we cannot say.

In any event, the New Jersey Association for Retarded Children recommends to this committee the implementation of the congressional long-range plan of training teachers, either by providing additional appropriations to enable the Office of Education to execute such a program, or by new companion legislation spelling out a direct mandate of grants to selected and qualified universities and colleges to create and develop departments of special education.

Departments of special education, staffed with trained faculties, are today few and far between. Creation of such departments of special education will enable our institutions of higher learning to teach student teachers the things that they must know and do with the mentally retarded youngster.

Our critical need, both now and in the future, is not only quantity, but also quality.

Our association is also very much interested in the independent living bill, H.R. 3465, and endorses its provisions completely. We who

are parents of mentally retarded children know that their intellectual range varies all the way from the crib case to the borderline case, with many gradations in between.

As a private agency, operating with our own funds, funds solicited from the public, and with funds provided by the New Jersey Rehabilitation Commission, we have met an unusually large number of cases where rehabilitation services would have resulted in less dependency, or employment under sheltered conditions in a terminal workshop.

None of these mental retardates were eligible for services because they could not be certified as having a reasonable expectation of being employable following rehabilitation services.

Our association sponsors—by itself and with other agencies—eight such workshops and occupational centers in New Jersey, in which about 200 mentally retarded persons are receiving services.

During the fiscal year 1958-59, 111 others were denied services because they did not completely fall within the definition of the existing law—or meet similar criteria of vocational training as provided by the workshop program—yet most, if not all of these 111 would have benefited by rehabilitation services; would have benefited by rehabilitation services and would have become less dependent on others, and would have achieved greater independence than before.

We heartily endorse the independent living bill as a recognition by its congressional sponsors that human beings, and mentally retarded persons are just such, should never be denied a chance for self-improvement.

These sheltered workshops and training centers are a new and significant development. The oldest was opened in 1954. There is much that they can learn from each other. Our workshops can learn from those in other States and, we hope, vice versa.

Last week the U.S. Office of Vocational Rehabilitation and the National Association for Retarded Children cosponsored a conference in Dallas, Tex., on research in behalf of the retarded, especially as exemplified by such workshops and training centers.

In talking with one of the two New Jerseyites who participated I was impressed with the value which such conferences can have on a national or regional basis, especially at this stage of the development of sheltered workshop idea.

We commend the Office of Vocational Rehabilitation for initiating this idea and hope they will receive encouragement from your committee.

Thank you very much.

MR. ELLIOTT. Thank you very much, Mr. Feinman. We appreciate your testimony.

STATEMENT BY JOSEPH FEINMAN, STATE CHAIRMAN OF THE LEGISLATIVE COMMITTEE OF THE NEW JERSEY ASSOCIATION FOR RETARDED CHILDREN

Mr. Chairman and honorable members of the Subcommittee on Special Education of the U.S. House of Representatives on Education and Labor, I appear on behalf of the New Jersey Association for Retarded Children, a nonprofit statewide organization of some 2,500 members, most of whom are parents of a mentally retarded child.

The tremendous postwar population growth of New Jersey, the heavy concentration in this State of military bases with an unusually large number of military transients in training, and the enactment in New Jersey of the Beadleston Act which guarantees education and training to the educable and

trainable mentally retarded—these have all resulted in a need for teachers trained to teach the mentally retarded. The most urgent need in New Jersey today in the field of special education for the mentally retarded is a critical shortage of trained teachers.

This critical need has been known to the Congress, which enacted legislation designed to provide a flow of such trained teachers. Under the National Defense Education Act, grants are provided to colleges and universities for fellowships to graduate students, and since the enactment of this law, one set of fellowships in the field of special education has been awarded by the Office of Education to Wayne University. Under Public Law 85-926, grants are also provided to colleges and universities for such fellowships, as well as further grants to State departments of education for fellowships and scholarships to those who desire to enter the field of teaching the mentally retarded.

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The laws adopted by Congress to date, to fill this acknowledged void, have been both long range and short range, in nature. Implementation, however, has been short range only. Under Public Law 85-926, the Office of Education has acted in the direction of providing trained teachers as quickly as possible, and although Public Law 85-926 provides for Federal grants to colleges and universities to help underwrite programs for training of teachers of teachers of the mentally retarded, i.e., creation of a faculty of special education, nevertheless the Office of Education has been unable to do anything in this direction. Whether because of lack of funds, or because of the lack of a direct congressional mandate, we cannot say. In any event, the New Jersey Association for Retarded Children recommends to this committee the implementation of the congressional long-range plan of training teachers of teachers, either by providing additional appropriations to enable the Office of Education to execute such a program, or by new companion legislation spelling out a direct mandate of grants to selected and qualified universities and colleges to create and develop departments of special education. Departments of special education, staffed with trained faculties, are today few and far between. Creation of such departments of special education will enable our institutions of higher learning to teach student teachers the things they must know and do with the mentally retarded youngster. Our critical need, both now and in the future, is not only quantity, but also quality.

Our association is also very much interested in the independent living bill (H.R. 3465) and endorses its provisions completely. We who are parents of mentally retarded children know that their intellectual range varies all the way from the crib case to the borderline case, with many gradations in between. As a private agency, operating with our own funds, funds solicited from the public, and with funds provided by the New Jersey Rehabilitation Commission, we have met an unusually large number of cases where rehabilitation services would have resulted in less dependency, or employment under sheltered conditions in a terminal workshop. None of these mental retardates were eligible for services because they could not be certified as having a reasonable expectation of being employable following rehabilitation services.

Our association sponsors (by itself and with other agencies) eight such workshops and occupational centers in New Jersey, in which about 220 mentally retarded persons are receiving services. During the fiscal year 1958-59, 111 others were denied services because they did not completely fall within the definition of the existing law or meet similar criteria of vocational training as provided by the workshop program, yet most, if not all of these 111 would have benefited by rehabilitation services—would have become less dependent on others, and would have achieved greater independence than before. We heartily endorse the independent living bill as a recognition by its congressional sponsors that human beings—and mentally retarded persons are just such—should never be denied a chance for self-improvement.

These sheltered workshops and training centers are a new and significant development; the oldest was opened in 1954. There is much they can learn from each other. Our workshops can learn from those in other States and—we hope—vice versa. Last week the U.S. Office of Vocational Rehabilitation and

the National Association for Retarded Children cosponsored a conference in Dallas, Tex., on research in behalf of the retarded, especially as exemplified by such workshops and training centers. In talking with one of the two New Jerseyites who participated, I was impressed with the value which such conferences can have on a national or regional basis, especially at this stage of the development of the sheltered workshop idea. We commend the Office of Vocational Rehabilitation for initiating this idea and hope they will receive encouragement from your committee.

Mr. ELLIOTT. Our next witness is William T. Wiest, Jr., executive director, Eastern Delaware Association for Retarded Children, Wilmington, Del.

Mr. Wiest, will you come around, sir?

**STATEMENT OF WILLIAM T. WIEST, JR., EXECUTIVE DIRECTOR,
DELAWARE ASSOCIATION FOR RETARDED CHILDREN, WILMINGTON, DEL.**

Mr. WIEST. Mr. Chairman, I brought with me Mr. Bart A. Milano, executive director of a sheltered workshop. Mr. Milano was invited by you to testify. However, this came to his attention too late to write to you for a chance.

If you are in agreement, I would be glad to share my time with him.

Mr. ELLIOTT. Yes, will you invite him around?

Mr. WIEST. Suppose I take 5 minutes for mine and give him the other 5 minutes?

Mr. ELLIOTT. That will be fine.

Mr. WIEST. I am here, Mr. Chairman, representing the Delaware State Association for Mentally Retarded Children.

Our reason for existing is to better the lives of the mentally retarded of all ages and degrees of handicap, as well as to promote basic research which may lead to the prevention and amelioration of mental retardation.

We have an estimated 10,000 to 12,000 mental retardates in our small State of Delaware, who are our most direct concern. We also work with our parent organization, the National Association for Retarded Children, and other organizations, to promote the welfare of the mentally retarded elsewhere.

I had the privilege of being invited to attend the section on mental retardation of the study group for the eastern Atlantic region which met in Philadelphia for 2 days earlier this week. While I was able to be in attendance only the first day that the study group met, I witnessed a lot of good thinking taking place and ideas being born concerning the identification, education and training, and vocational rehabilitation of the retarded.

I feel sure that whoever has been elected to present testimony for that group at this hearing will have much of interest to report.

I would like to limit my testimony to speaking out in favor of H.R. 3465, sometimes referred to as the independent living bill.

Section 201, title II of H.R. 3465, says, in part:

Authorization of appropriations for grants, purpose for which available, for the purpose of assisting the States in rehabilitating handicapped individuals who, as a result of such rehabilitation, may be expected to achieve such ability of independent living as to dispense with or largely dispense with the need for institutional care, or, if not institutionalized, to dispense with, or largely dis-

pense with, the need for an attendant, thereby reducing their burden upon others and contributing to their dignity and self-respect.

Under section 206 (b), title II, it reads:

The term "handicapped individual" means an individual of employable age, as defined by regulations of the Secretary, who is under such physical or mental disability as to require institutional care or attendance in his household continuously or for a substantial portion of the time, but who can be reasonably expected, as a result of rehabilitation services to achieve such ability of independent living that he will no longer require such institutional care or such attendance in his household.

I believe these definitions include a young man I know whom I shall call John. John, a Delawarean, is 22 years old and markedly mentally retarded. John is not alone. There are thousands like him in the United States.

John attended a parent-operated school for the trainable mentally retarded for several years before such classes were provided by our public schools in Delaware. Thereafter he attended a public school class for trainables for 2 years until he reached his 21st birthday, and had to leave because the schools could not legally keep him longer.

John then attended, on a trial basis, a sheltered workshop in Wilmington for the mentally and physically handicapped.

Although every effort was made on the part of the workshop staff to make John's trial a successful one, he did not make the grade. It was found that it was not possible for John to adjust to the requirements of the sheltered workshop and to profit from it.

In the report made at the time of his termination the idea was expressed that John's failure did not result so much from an intellectual inability to learn some of the simple, routine jobs done at the sheltered workshop, but, more from his present inability to conform to any kind of a work schedule. The door was left open for a future trial at the sheltered workshop if John could mature in his personal behavior.

Very possibly John would not be having this trouble today if we had had good schools for trainable children when he was very young and if, over the years, he could have been slowly, but systematically trained in a formal learning situation to make maximum use of his potential capacities, which even today are still apparent, but not fully exploited.

People did the best they could for John in his early life, but the facilities available were not adequate.

Within the next 5 to 10 years in Delaware, and perhaps longer in some parts of the country, I visualize similar casualties such as John, people who haven't really had much of a chance, even if they did manage to get into a class for trainables somewhere in the middle or latter part of their school-age years.

Even after the 5- to 10-year period I visualize similar casualties in cases where home or school is inadequate to meet the need.

I believe that many of these people can still be salvaged, but they will need an intermediate step between school and employment. They need a place where old habits can be broken down and new ones built up; a place where, taking as much time as may be necessary, these people can be helped to improve in personal maturity and develop good work habits—to be differentiated from work skills.

While this is not vocational rehabilitation in the broadest sense, it is rehabilitation in the fullest sense, and, I believe, frequently a vital step before vocational rehabilitation.

I have no doubt that some of the people with problems similar to John's—and I may add I believe that may be as many as one-half of those who terminate attendance in our public-school classes for trainables in the years immediately ahead—will be able to become partially self-supporting adults after an experience such as H.R. 3465 could provide.

I do not know how much there are, but I am guessing and I am afraid that my guess may be a conservative estimate that half of the people who finish our public-school classes for trainables in the years about to come will be like John. They possibly would be able to engage in some remunerative employment if they had been to an adequate training.

They don't have one which is not their fault, but I think they can still get it.

In addition to that, I would like to say I realize, too, that some of these people, even with this special training, are not going to be able to do remunerative employment. I know that some will.

I would not even want to hazard a guess as to how many won't be able to. I would like to say, though, even so I think the money will be very well invested.

In many of these cases the experience will make it unnecessary to institutionalize the retardate or will greatly reduce the amount of attendance and custodial care he will require at home.

To top all this, these people will have a place to go each day where they will engage in a constructive program with their peers. They need not be the misfits who sit at home with nothing to do while parents, brothers, and sisters pursue their various vocational, educational, and recreational pursuits.

To go back to section 201, title II of H.R. 3465, this bill has the potentiality of doing exactly what this section says: "reducing their burden upon others and contributing to their dignity and self-respect."

How can a society with our fine Judaic-Christian heritage think of doing less for them?

Thank you.

Mr. ELLIOTT. Mr. Wiest, if you are going to give the other gentleman half your time, I guess we will have to stop here.

Mr. WIEST. Thank you.

This is Mr. Bart Milano, executive director of Opportunities Center, Inc., a sheltered workshop in Delaware.

Mr. ELLIOTT. What town of Delaware are you from?

**STATEMENT OF BART A. MILANO, EXECUTIVE DIRECTOR,
OPPORTUNITY CENTER, INC., WILMINGTON, DEL.**

Mr. MILANO. Wilmington, sir.

I am executive director of Opportunity Center, Inc., a workshop for training and employing the handicapped, located in Wilmington, Del.

We started operating in 1957 with 2 employees and now have 102 disabled persons in training and employment.

Our center serves all types of handicapped, physically, mentally retarded, and emotionally disturbed. We do work primarily on a contract basis, and we have the following departments: Printing, photography, clerical, upholstery, refinishing, woodshop, sewing, letter shop, radio, television, and appliance repair; in addition we do various miscellaneous work, such as packaging, sign lettering, car washing and polishing, mailing, stuffing and sealing envelopes, and so forth.

To date we have placed in competitive employment 32 persons.

In 1958 we applied for and received a Federal grant for the establishment of a demonstration project, a work-adjustment program for the severely handicapped. This is a 3-year project and, after being in operation for a year and a half, 90 disabled persons have been given an evaluation period under actual working conditions, to determine their ability to work, and to teach them proper work habits and work behavior.

We appreciate the help of the Federal Government in this important phase of our work.

I would also like to mention the cooperation given to us by the Delaware Vocational Rehabilitation Division. This agency, under its director, John G. King, screens all applicants referred to our workshop, and provides all the diagnosis for them, medical as well as psychological.

The agency's counselors supervise the persons during the work-adjustment training, the vocational training which follows, and also helps in placing them. We feel that this relationship between a private organization and a State-Federal one is an excellent one, and helps us jointly to help the disabled.

We feel that our workshop is now an important part of the community, since by providing jobs we have helped to lessen somewhat the burden on the taxpayer.

It is interesting to note that many of our employees were receiving public-welfare benefits, or were in tax-supported institutions, at time of referral to the Delaware Vocational Rehabilitation Division. There were 72 disabled persons at the center during the past year alone, whose source of support was from welfare or an institution; 29 of these were receiving State welfare; 13 were in the Delaware State Hospital mental institutions; 8 were in a State health center; 7 were in the State hospital for the mentally retarded; 13 were in other tax-supported State institutions; and 2 were supported by private institutions.

Our workshop will probably need to be expanded, and we have need for a similar workshop in the downstate area.

It is extremely difficult to initiate and to keep in operation such workshops without financial assistance from many sources.

The Federal Government was aware of this and has, through Public Law 565, the Vocational Rehabilitation Amendments of 1954, provided grants for the establishment of facilities.

However, except for demonstration grants, most Federal grants for workshops provide that such workshops must be comprehensive in nature, that is, provide medical as well as diagnostic and training services.

In most areas the medical services are already established and workshops do not want to duplicate any services.

We feel that workshops are needed throughout the country, and that the Federal Government could render valuable assistance in helping to establish workshops only for training and employing the handicapped, excluding the medical service requirement.

H.R. 3465 also provides for establishing rehabilitation centers and workshops and I am heartily in favor of this bill. I am not sure whether medical services have to be a part of the workshop or not—I hope not, since we in Delaware have fine medical facilities, but do need places to train and especially employ the disabled in a sheltered workshop type of facility.

Mr. ELLIOTT. Thank you very much for your kindness.

Is the Reverend Richard M. McGinnis, director of Mount Carmel Guild, here?

Father MCGINNIS. Yes, sir.

Mr. ELLIOTT. Will you come around, Father McGinnis?

STATEMENT OF REV. RICHARD M. MCGINNIS, DIRECTOR, MOUNT CARMEL GUILD, NEWARK, N.J.

Father MCGINNIS. If it is agreeable with the committee, I would like to express my thanks for coming here. I would like to submit my report in written fashion tomorrow.

Mr. ELLIOTT. Without objection, the report of the Reverend Richard M. McGinnis, director of the Mount Carmel Guild, will be made a part of the record at this point when the report has been submitted.

Will you state for the record just a word about your background, Father?

Father MCGINNIS. I am director of the Mount Carmel Guild Center for the Blind in Newark, which is an agency which has educational and rehabilitative classes for the blind as well as social activities.

We work with over 800 blind people of this area. Our center is located at 99 Central Avenue, Newark, N.J. We have a system of classes in the evening which we hope will make all persons more independent and better able to live in the world. That is the purpose of our program.

Mr. ELLIOTT. How old is your institution?

Father MCGINNIS. Our department for the blind is actually 20 years old and has had a central meeting place, a central location where these activities have been carried on over the last 4 years.

Mr. ELLIOTT. Thank you very much, Father.

Our next witness is Mr. James Fraser, of Goodwill Industries, Camden, N.J., executive director of Goodwill Industries.

You may proceed, Mr. Fraser.

I regret that we must limit you to 10 minutes.

STATEMENT OF JAMES FRASER, EXECUTIVE DIRECTOR, GOODWILL INDUSTRIES OF SOUTHERN NEW JERSEY

Mr. FRASER. I wish to express my sincere appreciation for this privilege of appearing at this important meeting.

I would like to give a brief history of the progress of the Goodwill Industries of Southern New Jersey, because it is pertinent to some of the facts that I wish to state later.

Mr. ELLIOTT. Let me ask you a question: How many Goodwill Industries are there in America?

Mr. FRASER. 122.

Mr. ELLIOTT. In every State?

Mr. FRASER. That is in every State.

Mr. ELLIOTT. How many people do those industries employ as of now?

Mr. FRASER. I think it is about 22,000.

Mr. ELLIOTT. Thank you, sir.

Mr. FRASER. We were organized in April 1950, in the back room of a small church in South Camden, two handicapped employees were hired and a privately owned station wagon was borrowed at this point.

Shortly thereafter a three-story building was rented with a 20-foot store front. By 1953 the organization had purchased a 12,000-square-foot building with 14 handicapped employees and a yearly budget of less than \$40,000.

In 1958, a 38,000-square-foot building was purchased. At the conclusion of 1959 the annual budget had grown to \$150,000 and 80 persons were on the payroll and, as you might surmise, this growth had many causes.

We wish to acknowledge with gratitude the highest praise for the help and interest in our program shown by the members of the New Jersey State Rehabilitation Commission.

We have also been assisted by the Veterans' Administration and the Camden County United Fund, and in 1957 we received Federal and State grants under section 4(a) (2) Vocational Rehabilitation Act.

This came at the most opportune time for our growth. With these improved facilities, our program took an immediate advancement in our possibilities of serving the handicapped of our area. We are sure because of building space and a backlog of over 200 applicants and there would be many, many more if we solicited them, we can make further advance in our services to the handicapped.

I would like to give you some of our thinking and plans for the future:

1. We wish to increase the prime factor of our program which is to give employment to the handicapped persons who find it next to impossible to get such employment in normal industries.

This will be done by expanding our work program of used goods.

2. We have need for contract work such as assembling and simple manufacturing for handicapped people that need to be seated while working.

This need could be supplemented by Government subcontracts. We urge that we be considered in such contracts.

3. We hope to increase in amount and in proficiency our present training program for the handicapped in cooperation with the State rehabilitation commission and the Veterans' Administration.

4. We hope to fulfill a need in our areas either by ourselves or in cooperation with other agencies some rehabilitation in the form of clinic needs, for instance, periodic physical examinations by a physician to determine the capacity or limits of our employes for working.

As more and more retarded clients appeal to us and are employed, we also feel the need of psychiatric examinations to determine their capacities and advancement. We hope to improve our counseling

and social services and to be able to do this we feel the great need for professional training to prepare staff for these projects. We would like to emphasize and urge this need for the training of such professional help.

We have become aware of the need for workshop help in other areas of our territory, mainly Mercer County, of which Trenton, our capital, is in center. Also, in Cumberland and surrounding counties in the southern part of our State.

As this area is largely rural and farm, we are contemplating a farm help training program for the retarded and other handicapped.

With moderate help this portion of our population could be given the same benefits of help provided elsewhere.

In cooperation with the Union Organizations for Social Services, sponsored by the Joint Council of AFL and CIO of Camden County, we are contemplating opening a recreation and service project for aged and retired persons of this area. This will provide recreation, entertainment, meeting place, lunch facilities, counseling, and other type of assistance that can be given to the aged. This could also be used as a base for independent living rehabilitation.

We know that our program for the future is a momentous one, but with some assistance, which must be gotten outside of our nonprofit program, advancement can be made in all these fields and our plans completed.

I again wish to express my appreciation for this privilege of presenting this testimony in behalf of the handicapped persons in the southern half of New Jersey.

Thank you.

MR. ELLIOTT. Thank you very much, Mr. Fraser.

MR. FRASER. Thank you, Mr. Chairman.

MR. ELLIOTT. I recognize Dr. Barnard for a request now.

DR. BARNARD. Mr. Chairman, I would like to request that the statement of Mr. Philip M. Hyman, executive director for the Associated Placement and Guidance Bureau, be made an official part of the record at this point.

MR. ELLIOTT. Mr. Hyman is from Baltimore?

DR. BARNARD. Yes, sir.

MR. ELLIOTT. Without objection, the statement of Mr. Hyman will be made a part of the record at this point.

(The statement referred to follows:)

STATEMENT OF PHILIP M. HYMAN, EXECUTIVE DIRECTOR, ASSOCIATED PLACEMENT
AND GUIDANCE BUREAU

I am a placement counselor employed in a private social agency. Our main focus is to place handicapped persons in suitable employment. We direct such skills as we possess toward an alinement between handicapped jobseekers and industry's personnel needs. Our financial support comes from the Associated Jewish Charities of Baltimore. We receive no subsidies from the Federal, State, or municipal government, but we do utilize and lean heavily on our State rehabilitation service for vocational training and retraining of our handicapped clients.

In these brief minutes allotted me I will not attempt to saturate this hearing with statistics on our unmet social needs in Baltimore and the State of Maryland. Congressman Elliott's bills clearly recognize these deficiencies and I am certain that each community across these United States has generic problems and kindred frustrations.

Prior to this meeting I visited with Mr. R. C. Thompson, State director of the Division of Vocational Rehabilitation of the State of Maryland. I learned that

his agency has been able to service less than one-third of all eligible applicants who require rehabilitative services. Thirty-five counselors cover the State with an average caseload of 200 clients. When funds which are earmarked for rehabilitative purposes are exhausted during any given year, this agency, of necessity, must deny services until the next fiscal year. Thirty-five counselors are heavily burdened with a caseload that should be distributed between 100 counselors. An ongoing year-round, inservice training program for vocational counselors in this agency is recommended by Mr. Thompson in order to enhance their effectiveness by keeping abreast with changes and trends in their field.

Our sheltered workshops are loaded to maximum client capacity almost all of the time. Two of our largest shops are of the terminal variety and are populated largely with a clientele so severely handicapped that their employment in a competitive setting is hardly possible. Periodic layoffs occur at these shops because of the lack of funds or lack of contracts or both of these.

I have studied with a great deal of interest Congressman Elliott's bill dealing with independent living and subscribe in principle to his purposes regarding the social and economic salvaging of our human resources. I agree with him that, given the proper tools and professional know-how, a much more effective rehabilitation job can be done, must be done, and will be done.

If our handicapped population do not receive the benefit of a thoroughgoing vocation training program which is realistically attuned to modern industrial needs, then our communities will be faced with relief costs that could reach staggering and fantastic proportions. The cheapest buy in this country when measured in terms of human and dollar values is vocational rehabilitation; the most expensive buy is a laissez-faire attitude. Each handicapped, untrained, unskilled, and unemployed person in our country who is even marginally salvagable in an economic and social sense should be exposed to whatever rehabilitative resources we possess. And, if our rehabilitation processes are ineffectual then, they should be overhauled and strengthened. We cannot have a strong America unless we have a gainfully employed America. Industry will buy productive workers only; it cannot afford anything else.

I do not believe that Congressman Elliott's bill for independent living is a sinister in-patient versus out-patient issue as some of my more apprehensive colleagues are inferring. Congressman Elliott is, I trust, fully aware of the facts and undoubtedly recognizes that a statistically certain percentage of hard cores among the handicapped are beyond reclaim regardless of what modern medical psychiatric and educational techniques we employ. His bill, as I see it, means to harness all of our National and State rehabilitation resources, put the thing into high gear, salvage the salvagables, cut down on "expensive institutional care" and restore to many of the handicapped their dignity and self-respect.

I should like to see appended to the independent living bill a request to the Secretary that the Governors of our States appoint training and employment advisory councils composed of local businessmen wherever rehabilitation facilities exist. Job training for the handicapped should be indigenous to the employment opportunities usually available in local communities wherever and whenever practical. It is reasonable to assume that management will cooperate and contribute valuable suggestions as to the soundness and validity of training programs as it relates to their own local labor needs.

I salute and applaud Congressman Elliott's goals as expressed and implied in his independent living bill. It is most comforting and reassuring to those of us who toil in the vineyards of rehabilitation work to know that a strong voice and force has been raised in behalf of the hurt, the frightened, and the insecure.

Mr. ELLIOTT. Our next witness is Dr. Kingsley Price, of the Department of Philosophy and Education of Johns Hopkins University.

Dr. Kingsley Price.

STATEMENT OF DR. KINGSLEY PRICE, DEPARTMENT OF PHILOSOPHY AND EDUCATION, JOHNS HOPKINS UNIVERSITY

Mr. PRICE. Mr. Chairman and members of the subcommittee, I want to thank you for letting me talk to you today in your proceedings.

I would like, if I may, to tell you just a little bit about who I am, which will, I think, clarify some of the points I want to make later.

Second, to make some remarks about the objectives of education of the blind and rehabilitate the blind and, third, to mention two kinds of needs of the blind which I think these programs at present do not completely satisfy.

I am not, myself, connected in any professional way with work for the blind. I never have held a position of this sort and I do not expect to.

I am a teacher at Johns Hopkins University. I write on philosophical topics and I expect to spend the rest of my life doing this kind of work and perhaps being a scholar of the literature of philosophy.

Nevertheless, from my college days as a blind person I have had a warm and active interest in the problems of the blind and have worked part of my spare time with organizations of the blind who were concerned in solving these problems.

Continuing that nonprofessional interest, I am now a member of the advisory committee on book selection to the Library of Congress Division for the Blind, and a member of the board of directors of the National Federation of the Blind, which I believe I may say I represent here today.

Mr. ELLIOTT. Do you represent and speak for the National Federation of the Blind?

Mr. PRICE. That is right.

Now, gentlemen, I would like very briefly to remind you of the kind of objective which I think all would entertain for education of the blind person and for their rehabilitation.

Blind children and blind youth are not as such peculiar. What is common to them is the fact that they are blind. No other personality traits, no personality traits are inherently accompaniments of blindness.

Consequently, a group of blind children and blind youth, unlike some of the other groups with which you are concerned, do not indicate any peculiar kinds of interest or capacity or talent or taste.

They are, except for the fact that they are blind, random cross section of the population of children and youth.

The objective, therefore, of educating them and the aim of rehabilitating them is not an objective which is devoted to making them acquire some particular kind of interest or for satisfying some particular kind of need. In educating them, the problem is through ways different from those employed for sighted children and youth to enable them to realize their peculiar interests and talents and capacities and the job of rehabilitating them is of enabling them in different ways to do exactly what normal, that is to say, sighted persons, do; namely, earn their own living.

I should like to emphasize that the objective, then, of educating and rehabilitating is simply to enable blind children and youth to do everything that anybody else can do, although they must do them often in different ways.

Secondly, I should like to mention two needs which I think, in the light of this kind of objective, we may properly regard as presently not thoroughly met. In order to teach children and youth who are blind, books must be available to them. The chief source of books available to blind college students and one of the important sources of books available to blind children below that level is the Library of Congress Division for the Blind.

The Library of Congress Division for the Blind makes available books in sound media, voice recordings, that is, and in braille, both press braille and hand-copied braille books.

At the present time, I imagine among other things for lack of financial support, the collection of books in the Library of Congress is not representative of the world's literature. Neither representative of the world's descriptive literature, the kinds of books that are required in courses in the social sciences and the natural sciences, nor is it representative of the world's imaginative literature—of novels, poetry, drama, and the like.

I would suggest that the committee might like to consider the possibility of increasing the appropriation for the Library of Congress with the specific purpose of enabling it to make a more representative collection.

At the present time the books in the collection are chiefly of an entertainment sort. That is not entirely true, but it is roughly true.

Mr. ELLIOTT. How many separate titles do we have?

Mr. PRICE. I could not tell you. They have a considerable number, but I am not in a position to say.

However, this does introduce the second remark that I wanted to make about the Library of Congress collection.

At present there is no comprehensive catalog of the books which the Library does contain in sound media, in voice recording, and in braille.

It is no doubt a very considerable task to make such a catalog, but I would remind the members of the committee that the users of the Division for the Blind, Library of Congress, are located all over the country. The books are distributed through regional libraries, though they are part of the collection of the Library of Congress, so that those who use it cannot come to the Library of Congress Division for the Blind and look through the card catalog to see what is there.

If there were a catalog available and kept up to date by regular supplements, the blind students throughout the country would find the holdings of the Library enormously more accessible and they would be able to make much better use of the collection than it is now possible to do.

There are no doubt considerable difficulties in making such a catalog, but I would suggest to the committee that legislation, if that be necessary, or an appropriation destined for that purpose, be considered.

Very briefly, I should like to mention a third inadequacy of the collection, which is not so much an inadequacy really, as a way in which it could be improved, which it does not at present endeavor even.

There are a large number of aspects of the world which are at present inaccessible to the blind, but in which we are interested and the improvement for which they might very well be talented.

I have in mind, first, the architectural and sculptural monuments, which are a regular part of the education of the sighted children.

At present there are no models of these which the blind child can examine.

It would be enormously helpful if some research could be started which would consider the problem of making available three-dimensional models of important piece of architecture, such as, for example, St. Peters, as the White House, and the Guggenheimer Museum, and, indeed, as the building in which we are now sitting.

If models of such things were available to blind children, they would learn a great deal which at present words, which is all that is available to them, cannot possibly describe for them.

It would also develop a lot of talents which now go unnoticed. Research on that might be helpful.

May I take one more minute, Mr. Chairman?

Mr. ELLIOTT. Yes, sir.

Mr. PRICE. The other unmet need that I wanted to mention is this: I think that those who are busy with the administration of programs for the blind very easily, with the best of intentions and the most human of motives, very easily find themselves pushed into an attitude which is not the most helpful, although it is extremely difficult to avoid.

They are dealing with people who are blind and to whom they have to give special ways of doing things. It becomes very easy for administrators of educational programs and rehabilitation programs to develop rules, to develop tests, to develop general principles, according to which blind clients and blind students are measured and predicted and understood.

This is no doubt a useful procedure, but I think there is a great danger that administrators, being extremely busy people, would rely upon it too much. I think with blind persons, as with all persons, there is a great amount of talent and interest which can neither be adequately measured and ascertained by tests now available nor predicted with any great degree of reliability.

I would like to suggest that this difficulty, which is almost inherent in administration, might be very much lessened if there were legislation encouraging educators, educational administrators, and rehabilitation persons and bureaus to consult with mature blind persons upon their problems and upon the manner in which they can be solved.

The need for consultation of blind persons is the second need which I think at present goes unmet. I am sure I have taken up my 10 minutes.

Mr. ELLIOTT. Thank you very much, Dr. Price.

I recognize the gentleman from Minnesota, Mr. Quie.

Mr. QUIE. Dr. Price, you are quite familiar with the facilities that the Library of Congress provides. Do you feel that where these regional libraries now exist they have sufficient buildings or area to house the present talking books?

Mr. PRICE. I think, sir, that there is probably a very considerable problem on that score. I have heard complaints about it from various sources.

I am not in an authoritative position to answer your question, but I certainly have heard a great deal of complaint on that score.

People want to give services, but there really are problems, and staff I imagine, too.

Mr. QUIE. Secondly, on those models so that children in the schools can get a feel of the architecture and other objects, can you cite any schools that have done a good job of providing that themselves?

Mr. PRICE. There used to be some of this material available. I think that it was not much used. At any rate, the blind persons with whom I am acquainted, which is a very large number, none of them, I think, would be willing to boast even a rudimentary knowledge of

the important monuments of architecture or sculpture. It is perhaps partly difficulty of getting teachers to use these materials.

That was some time ago when they were available. I think at present there are very few of these materials.

MR. ELLIOTT. I recognize the gentleman from New Jersey, Mr. Daniels.

MR. DANIELS. Dr. Price, as to your first recommendation, have you given any consideration as to the cost of reproducing in braille for the benefit of the blind people literature of a better reading quality? Have you conducted a survey of any kind?

MR. PRICE. You mean of a better physical quality?

MR. DANIELS. Yes.

MR. PRICE. No; I think, however, that the braille, and also the recordings which are presently available to the Library of Congress, are excellent. Technically, they do a marvelous job.

MR. DANIELS. Could you furnish this committee with any information as to the cost of reproduction in braille of the type of literature that you are recommending to this committee?

MR. PRICE. I cannot give you any very sensible notion on that score; no, sir. It may be that my colleague, Mr. Nagel, of the National Federation of the Blind, who is present, does have such information.

MR. DANIELS. Thank you.

MR. ELLIOTT. Thank you very much, Dr. Price, for your fine testimony.

STATEMENT OF DR. KINGSLEY PRICE

Mr. Chairman and members of the subcommittee, I would like to tell you something about myself because this information will make my later remarks more intelligible. I am an associate professor in philosophy and education at the Johns Hopkins University. I never have held a position in work for the blind and do not expect to do so in the future. I am a teacher of philosophy, including philosophy of education. I write on philosophical topics, and, at least to some degree, am a scholar of the literature of philosophy. I expect to spend the rest of my life doing these things. I have no professional stake in any kind of program of work for the blind.

Nonetheless, I have, since my college days, felt a warm interest in the problem of the blind and have spent part of my spare time working with organizations of the blind to bring about a solution of their problems. At present, I am a member of the Advisory Committee on Book Selection of the Division for the Blind of the Library of Congress. I am also a member of the board of directors of the National Federation of the Blind. Today, I represent the National Federation of the Blind in these hearings.

I would like, first, to make some general remarks concerning the aims and objectives of education and rehabilitation of the blind; and, secondly, to set forth briefly two kinds of needs of blind persons which are now not adequately met by programs for their education and rehabilitation.

1. First, the aims and objectives of educating and rehabilitating blind persons are not, in their nature, different from those of the education and rehabilitation of any other group. Blindness carries with it no other traits. Consequently, blind children and adults are characterized by no other property than that of blindness. They are no more like one another than would be the children and adults of any randomly chosen group—no more like one another, that is, except for their deficiency of vision. It follows that the capacities and interests, the talents and the tastes of blind children and adults are of no peculiar sort, and that they range over as wide an area as do those of sighted persons.

The objectives of education and of rehabilitation must be understood in terms of the capacities and interests, the talents and the tastes of those to be educated and rehabilitated. A person is educated to the degree that he has acquired the means of exercising his capacities, realizing his interests, and developing his talents and tastes. He is rehabilitated to the degree that the

obstacles to earning his livelihood have been overcome. Since blind children and adults, as such, do not exhibit any peculiar psychological structure, there is no proper restriction on the direction which their education should assume, and almost no restriction on the kind of economic activity toward which their rehabilitation should aim. Of course, the blind cannot be rehabilitated by teaching them to be chauffeurs and professional baseball players. But since blindness carries with it no other physical or psychological trait, no other physical or psychological capacity or incapacity, blindness dictates no peculiar kind of education, and demands no particular type of rehabilitation. In this respect the blind differ from other groups with which this subcommittee must be concerned. Their difference lies in the fact that what characterizes them, their blindness, in no way whatever limits the kind of education they may legitimately require, and the kind of rehabilitation (with a very few obvious exceptions) for which they may properly hope. What they should learn, and what they should learn how to do by way of livelihood should be no more restricted than is that of any randomly selected group. The business of education and rehabilitation of the blind is that of enabling them to learn and to do what might be learned or done by anyone else, but to learn and to do it in a different way.

II. In the light of this objective, there are two kinds of needs from which blind children and adults suffer, and which are now not adequately satisfied.

1. First, there is the need for materials which will enable blind children and adults to become aware of what the world contains, i.e., to become aware of the contents of their cultural heritage, as well as of the physical universe. These materials are of two kinds. The first are books.

(a) The chief source of books for blind children and adults is the Division for the Blind, Library of Congress. This is not the only source. The American Printing House for the Blind makes available to the lower schools such books as its presently restrictive quota system permits. But it remains true that the Library of Congress, Division for the Blind, is the largest single source for reading materials for blind children and adults generally.

The holdings of the Division for the Blind, Library of Congress, consist chiefly of braille books (both machine made and hand transcribed) and of books recorded in voice media (chiefly on disks, talking book records). These books are sent to blind persons throughout the Nation, in part through the medium of State libraries and in part directly from the Library of Congress.

The holdings of the Division for the Blind, Library of Congress, are altogether inadequate to meet the educational needs of blind children and adults. They consist almost wholly of books of light entertainment. Their character is, generally, bland, escapist, and mediocre. The great imaginative and descriptive literature of the world is almost unrepresented. Serious novelists, poets, and dramatists make almost no appearance on the shelves and the literature of the social and natural sciences (mathematics, physics, biology, etc.) of philosophy, theology, and the humanities generally, is almost completely absent. There is a great need for a collection of books in braille and on voice records which is representative of the world's literature; and this collection would naturally grow out of an improvement of the holdings of the Division for the Blind, Library of Congress.

I would like to suggest that the subcommittee consider legislation which would increase the appropriation for the Library of Congress, Division for the Blind, in order that its collection of braille and voice-recorded books should be made adequately representative of the world's literature; and that it consider, further, the advisability of offering an amendment to the appropriate statutes which would insure this kind of improvement of the collection held by the Library of Congress, Division for the Blind.

(b) The second kind of materials which would be of enormous use to blind children and adults are three-dimensional models. These models would serve two uses. First, they would provide representation in three dimensions of important works of sculpture and architecture. Secondly, they would provide in an immediate form, much more effective than verbal descriptions, the nature of many physical facts, e.g., geographical structures, such as continents, islands, etc., and astronomical concepts, such as the ecliptic. At present a variety of such models are available to the sighted who have the advantage of observing both their tangible and abstract forms but the blind have no such privilege. Blind children and adults are, consequently, entirely cut off from one important dimension of life. They have no way of knowing or understanding the arts of

architecture and of sculpture. This phase of their education is almost utterly neglected. The use of models to explain geographical facts and astronomical concepts is not quite so meager but very nearly so. It would be an enormous improvement in the education of the blind if models were readily available which could bring them an acquaintance with Chartres, St. Peters, the White House, the Guggenheim Museum, or, for that matter, the building in which this subcommittee is holding these hearings; and if they could be shown what the great sculptors of the past and the present have created. Their learning of what the physical world contains would be greatly facilitated if the number and variety of relief maps and similar materials were greatly increased.

I suggest that the subcommittee consider measures which would make available to blind children and adults models of sculpture and architecture and other models helpful in showing what the world is like; and that the subcommittee consider making these materials available through the Library of Congress, Division for the Blind, on a loan basis.

I suggest, further, that the subcommittee consider Federal support of research, the purpose of which would be to investigate the possibility of translating painting, drawing, and other kinds of two-dimensional art into three-dimensional relief. Little is known about how much can be translated from a medium which is primarily visual into one which is primarily tactual, but since it would be a great improvement in the education of the blind if they could know something about the history of two-dimensional art, this research would be very much worth carrying on, no matter what its outcome.

(c) I should like to mention, now, a third aspect of unmet needs with respect to the Library of Congress, Division for the Blind. The materials held in the collection of the Division are used by blind children and adults who live throughout the entire Nation. Books which the Division contains are distributed through State and other libraries. The users of the collection cannot be expected to travel to the State or other distributing library, or to the Library of Congress in Washington, D.C., in order to find out what books are available to them. The blind reader cannot look through the collection of books in Braille or in voice recording which are presently available to him. Moreover, there is a considerable number of books available to blind readers in libraries which have no connection whatever with the Library of Congress, but which are available to blind readers on a nationwide basis.

I would like to suggest that the subcommittee consider taking measures which would insure the creation of a comprehensive union catalog of Braille and voice-recorded books presently held by the Library of Congress, as well as by other libraries, to which catalog regular supplements would be made with sufficient frequency to guarantee reasonable currency.

2. The second kind of unmet need from which blind children and adults suffer is a need to be considered as individual human beings in their own right. There is a very widespread tendency among administrators of programs for the blind to regard those whose advancement their programs should further as little more than things to be manipulated in accord with the routines which they have inherited from their administrative predecessors. The blind child or adult is all too frequently thought of as something to be helped in a specified and familiar way. The administrator forgets that the subjects of his administration are persons and not simply things to be dealt with according to a certain set of rules, and according to a certain pattern of administrative behavior—that the test of those rules and that pattern is utility in advancing the proper purposes of his administration.

This failure is typified in what, as far as I can tell, is the attitude which actuates the administration of the Library of Congress, Division for the Blind. An examination of the books which are made available to blind children and adults under the aegis of this organization unavoidably suggests that those books are selected on the principle that the blind reader is something to be protected against the world rather than instructed as to its contents. Only such an attitude could explain the blandness and the mediocrity which typifies the collection. This attitude, no doubt, is much the most comfortable for the administrators of a library. It encourages among the readers a lack of imagination and independence of thought, while it assures the absence from the Library shelves of any books sufficiently interesting to incur objection. What it does not do, however, is what it ought properly to endeavor—namely, to further the exercise of the right to read on the part of the blind, which right on the part of others other libraries genuinely endeavor to foster and enable.

But the Library of Congress, Division for the Blind, is by no means the only organization which, for whatever reason, succeeds in frustrating the aims of education and rehabilitation. To treat the blind child and adult as something to be helped according to uncritically accepted rules, independent of any question of their utility, is a practice widespread in the administration of education and rehabilitation programs. It is easier to treat the blind in this way since any attention to the individual and unique capacities of such children and adults requires more work and effort. This is no indictment of the motives of individual persons. It is a statement, rather, of a natural tendency of all administrative organizations. The tendency on the part of those who make them up is to simplify each part of their work in view of the time-consuming functions which they are expected to perform. Nonetheless, it must be said that the primary objective of educating and rehabilitating the blind, the objective of furthering the realization of those interests and capacities which each blind child and adult harbor is presently frustrated by administrative inertia.

The administrator's failure to further the rights and interests of blind children and adults can be greatly diminished if blind persons are consulted, from time to time, upon the efficacy of existing programs, and upon the need for new and more imaginative policies.

I would like to recommend that the subcommittee consider legislation which would assure that those who administer programs of education and rehabilitation of the blind would, from time to time, consult representatives of the blind themselves upon the efficacy of their programs and upon ways of improvement.

III. Conclusion. The objective of educating the blind is to further the interests and capabilities, the talents and tastes of each child and adult involved, but to further no particular kind of interest or capacity, taste or talent, since no such particular one characterizes blind persons, as such. The objective of rehabilitation of the blind is that of enabling them to offset their blindness in order to earn a livelihood, but it is not to provide for them any particular kind of profession, vocation, or work since no particular kind of such capacity accompanies blindness. It follows that the objective of educating and rehabilitating the blind is simply that of fostering in them special ways of learning and doing what anyone else might learn or do, special ways, that is, of realizing their own individual selves.

The collection of the Library of Congress, Division for the Blind does not adequately assist in the realization of these objectives. The collection should be made more representative of the world's imaginative and descriptive literature, should include three-dimensional models of the world of art and nature, and should be described in a comprehensive, cumulative catalog of all the books available to the blind for their education and rehabilitation. Research should be instituted to see whether two-dimensional art might not be made accessible to the blind.

Administrative inertia and lack of imagination also prevents the realization of the objectives of education and rehabilitation. The individuality of blind children and adults needs to be protected and its realization assured by a diminution of this inertia. A necessary part of such diminution is consultation of blind persons by those who are charged with the administration of education and rehabilitation programs for the blind.

This is the objective of education and rehabilitation of the blind; and these are two important kinds of needs which, in the light of that objective, presently afflict the blind children and adults of this Nation.

Finally, Mr. Chairman, I wish to thank this subcommittee and the staff of its special study for the opportunity to testify here as well as serve as an invitee to the workshop on the visually impaired which concluded its deliberations yesterday afternoon, in Philadelphia. In urging a legislative mandate in favor of consultation with the blind themselves in the administration and execution of programs which bear directly upon them, the blind are simply asking that administrators of these programs afford them opportunities similar to those provided by this subcommittee and its special study staff. The advice and views of the blind should be made available to administrators of programs for their aid and rehabilitation through regularly established procedures. To fail to take this step is to reject a valuable source of experience and knowledge which could result in substantial program improvements—results which could be invaluable to administrators and the blind—those who administer the programs and those whom the programs are intended to benefit.

MR. ELLIOTT. Our next witness is Mrs. Audrey Spring. Mrs. Spring is the director of the North Jersey Hearing and Speech Center of Paterson, N.J.

Mrs. Spring, I am happy to recognize you. I recognize that you more than anybody else have been patient today.

You may proceed.

**STATEMENT OF MRS. AUDREY SPRING, DIRECTOR, NORTH JERSEY
HEARING AND SPEECH CENTER, PATERSON, N.J.**

Mrs. SPRING. To those of us who are concerned with the rehabilitation of the hearing and speech impaired person, the efforts of this Subcommittee on Special Education in the field of speech pathology and audiology are deeply appreciated and are of primary importance.

Consequently, the proposed House Joint Resolution No. 494 was studied and discussed in great detail by the board of directors, the professional staff, and the parents and patients of the North Jersey Hearing and Speech Center.

MR. ELLIOTT. How many people do you have at your North Jersey Speech Center?

Mrs. SPRING. We see about 60 children a week and about 20 adults a week, not counting our turnover.

MR. DANIELS. This is a voluntary organization?

Mrs. SPRING. Yes; Community Chest. We are in unanimity with legislators and previous speakers in their concern with programs that exist at present and in their desire to strengthen and expand the rehabilitation facilities in this field.

However, we wonder if this resolution provides the more expeditious and effective solution to our common problem. Perhaps the Federal expenditure of \$31½ million might be more profitably employed by improving the services to the deaf and hard of hearing and speech handicapped in a more direct manner.

The specific problem with which this resolution concerns itself is the paucity of students enrolling in the department of speech pathology and audiology in our institutions of higher learning.

This resolution recognizes that adequate educational facilities for these students exist, but admit the inability of these programs to attract larger numbers of students and yet our colleges and universities at present are not generally suffering from lack of applicants and are in fact becoming increasingly overtaxed.

Since other departments in our universities which are functioning at maximum capacity do not always receive subsidies or offer scholarships we must accept the possibility that working conditions and employment opportunities in our field do not provide adequate interest and incentive.

We are all cognizant of the fact that all of the students who do receive their degrees in hearing and speech fields do not continue, unfortunately, in these areas upon graduation.

Others remain in this field for only a short time. Still others are lost to our Federal, municipal, or community speech and hearing program centers or clinics when they elect to practice privately.

It is doubtful the subsidies or issuance of scholarships will remedy this situation. Rather, the following points are suggested as probable

causes for the insufficient number of professionals employed in our speech and hearing rehabilitation programs:

One, scarcity of adequate job opportunities in certain areas of the eastern Atlantic region. Although many hearing and speech positions remain unfilled in other areas of the region, our area, which is New Jersey, is concerned with the lack of hearing and speech facilities.

Of our school systems, many do not have any speech and hearing programs at all. Others are budgeted for only minimum programs employing a therapist only 1 day a week.

Further, community hearing and speech centers or those connected with hospitals or rehabilitation institutes, do not maintain adequate staff. In both cases the need for expanded speech and hearing services due to the constantly increasing demands of our communities, is evident.

Two, lack of incentive to personnel.

Too often our speech and hearing programs lose desirable candidates by their inability to offer adequate salaries and opportunities for personal advancement. In addition the necessarily large number of patients each therapist or teacher must see now is not conducive to professional growth or experience.

The therapist does not have sufficient time or energy to pursue further study, attend professional meetings, or conventions, and pursue activities in related fields.

These disadvantages are not the only ones that exist in our field, but are primarily important and are furthermore the most easily and effectively remedied by expenditure of public funds.

This remedy seems more feasible than the issuance of scholarships which might not result in the hoped for increase in manpower in our field.

Therefore, it is our considered opinion that, one, colleges and universities must institute more positive recruitment programs in speech pathology and audiology and the \$31½ million now planned for subsidies to colleges and universities might be more wisely spent by strengthening and expanding present speech and hearing facilities and by creating more programs that would result in more rewarding job opportunities.

A twofold purpose might be served in that way.

Firstly, positions in the field of audiology and speech pathology would be increased and made more attractive to student candidates;

Secondly, but of equal importance, better services to the deaf and hard of hearing of our community would be possible.

Mr. ELLIOTT. Thank you very much, Mrs. Springer.

Mrs. SPRINGER. Thank you.

Mr. ELLIOTT. Our next witness is Dr. Harold Scholl.

Dr. Scholl is acting chairman of the speech department and director of the speech and hearing center of Montclair State College, N.J.

**STATEMENT OF DR. HAROLD M. SCHOLL, ACTING CHAIRMAN,
SPEECH DEPARTMENT COORDINATOR, SPEECH AND HEARING
CENTER, MONTCLAIR STATE COLLEGE, MONTCLAIR, N.J.**

Dr. SCHOLL. Since the end of World War II, there has been increased public concern with the speech and language problems of children and adults. We have come to recognize the importance of

adequate oral communication for self-realization, vocational competency, social and emotional growth, and good citizenship.

We have failed to go much beyond the recognition stage, however, and often we become enmeshed in platitudes and philosophical discussion.

I am sure that the convincing testimony you have received to date has made you completely sympathetic and in agreement with the importance of speech rehabilitation.

It seems unnecessary at this point to engage in rhetorical pyrotechnics to persuade you further of the debilitating and handicapping effects of communicative disorders on the psychosocial and intellectual development of children and on the economic and personal life of young adults and senior citizens.

I doubt that anyone will argue about the value of therapeutic services, but the core of the problem lies in the lack of sufficient funds to carry out various aspects of a comprehensive program of speech habilitation and rehabilitation.

School boards cannot always find the money to make speech therapy services available to their children; adequate space and facilities for speech therapy are not always included in planning for school and rehabilitation centers since costs are critical; therapists with limited or substandard training cannot afford to go back to college for advanced training because of high tuition fees, and graduate programs cannot maintain small classes for those who do go back to school since the colleges depend on a high student to professor ratio.

We at Montclair State College are concerned with the training of undergraduate students who want to teach speech. We believe in providing a program that is broad in scope and rich in professional laboratory experiences.

Our basic philosophy is that all children need the services of a speech specialist, ranging from an enrichment and prevention program, to a remedial program.

We feel that a blending of the speech arts and sciences, in proper proportions, prepares a young man or woman to best meet the needs of all schoolchildren and to work successfully in enlisting the aid of classroom teachers, and the success of any speech correction program depends to a very large extent on the cooperation of the regular classroom teacher.

Training on the graduate level, however, is training in depth. Graduate students may enroll in a program leading to advanced clinical certification in speech and be prepared for the position of speech pathologist and for supervisor of speech services.

We also maintain a demonstration speech and hearing center at the college and have an enrollment of approximately 100 children. We maintain affiliations with the Rehabilitation Department at Mountainside Hospital, and with the North Jersey Training School—for mentally retarded girls.

We provide consultation services to the schools in neighboring communities and have conducted surveys of the speech needs of 17 school systems in New Jersey during the past 8 years.

It is within this framework of experience and interest that I should like to present some of the needs and problem areas with which we are concerned at Montclair State College.

It is estimated that 75,000 children have speech problems. Approximately 10,000 children are now receiving therapy in school programs.

New Jersey records indicate that in total there are 59 full-time and 15 part-time "teachers of the speech defective."

In order to service the remaining number, approximately 650 speech pathologists are needed for schoolchildren in regular classes and children in classes for the mentally retarded.

Out of some 600 school districts in New Jersey, only 25 employ one or more full-time teachers of speech. Of the 74 speech correctionists, 14 have only emergency endorsements.

In addition, most correction work at the moment is located in northern New Jersey. As low as the numbers are, speech correction is practically unheard of in very rural areas in the southern part of the State.

College training programs: Montclair College has State and administration support in its program for preparing students as teachers of children and adults with speech disorders. The extent of the support, however, is financially limited.

At the present time, we have the largest number of students enrolled in the speech major of any college in New Jersey and we still cannot fill the large number of employer requests for trained speech personnel.

We need support in recruiting larger numbers of capable young people to the profession through publications, career clinics, institutes, et cetera.

Few high school students today are aware of speech rehabilitation as a profession.

We also need to attract more men to the profession to minimize the turnover that we have because there are so many women doing special therapy work.

With an increased student enrollment, present facilities become inadequate. Federal assistance to the State may be needed to help establish comprehensive education clinics in which many disciplines are coordinated and all future teachers and specialists may observe and participate.

In addition to inadequacy of facilities with expansion, adequate supervision becomes imperative and costly. Ideally, no student clinician should provide therapy without direct supervision. This is inconceivable in assigning the 15-semester-hour teaching load of a college professor.

If Federal funds were available for such purposes, practicing speech pathologists could be retained on an adjunct staff appointment to help supervise the very important clinical internship experience of the college students.

At present, supervision is on the basis of five students to one supervisor, whereas we feel it should be on a one-to-one basis while the student fulfills his prescribed 200 clock hours of clinical experience.

On the graduate level, the problem of supervision also obtains.

In addition, there is the very real problem of college finances. In the State of New Jersey, graduate study at the State colleges must pay its own way. It cannot be a losing proposition since there are no State funds to subsidize the programs.

Consequently, the average class size must be 22 students, and no fewer than 15. It is virtually impossible to consistently meet this requirement in the speech major.

When a program is just getting started, numbers are bound to be low. Requirements for matriculation for the master's degree cannot be met in many instances, and we are dealing with a field in which there exists a critical shortage of personnel to begin with.

Therefore, a very respectable class size for a graduate speech program would be between 7 and 10 students.

Unfortunately, the college cannot support this, and as a result the course is canceled and as many as 10 potential speech pathologists are denied the training they must and should have.

Federal aid to colleges instituting graduate programs would be tremendously valuable.

We are also very much in favor of House Resolution 494 as one possible solution to this problem because it may make it possible to recruit a greater number of capable students who could not otherwise afford the tuition costs.

There is one thing I would like to bring to your attention. We are one of the few colleges in the State that have conducted surveys of the needs of communities in New Jersey. We have gone into schools at the request of the board of education and screened thousands of children to find out what the needs are in these communities.

So far we have been to 17 school systems in New Jersey and we have found that the percentage is considerably higher than the 5-percent figure which was presented on the national level. It runs somewhat closer to 20 percent of children having severe defects.

We have used, in estimating the number of speech therapists we need in New Jersey, the 5-percent figure.

So this is a very conservative estimate.

The problem in some way may be due to the metropolitan area, to crowded conditions. Sometimes when we get into the more rural areas of New Jersey and do testing we find that there is a lower percentage of incidence of speech disorders.

We hardly ever find young people who stutter in some of the farm areas, but we do find quite a few in the metropolitan areas.

There is a second group we are concerned with, those children who are markedly atypical, who have multidisorders. We are constantly requested to provide services at the college for these children because no services in speech and hearing are available to them at the local level.

We are also concerned with the geriatric patients with chronic diseases, such as cerebral vascular accidents, Parkinson's disease, and laryngectomy. We have just skimmed the surface in these areas and a good deal more needs to be done.

On behalf of the members of the speech department at Montclair State College, I thank you for inviting me to present our needs and problems. We strongly urge the passage of pending legislation and hope that in the near future that our students and the speech handicapped citizens of New Jersey may be beneficiaries of your very significant proposals.

Thank you very much.

(The formal statement of Dr. Scholl follows:)

STATEMENT OF DR. HAROLD M. SCHOLL, MONTCLAIR STATE COLLEGE, UPPER MONTCLAIR, N.J.

Since the end of World War II, there has been increased public concern with the speech and language problems of children and adults. We have come to recognize the importance of adequate oral communication for self-realization, vocational competency, social and emotional growth, and good citizenship. We have failed to go much beyond the recognition stage, however, and often we become enmeshed in platitudes and philosophical discussions. I am sure that the convincing testimony you have received to date has made you completely sympathetic and in agreement with the importance of speech rehabilitation. It seems unnecessary at this point to engage in rhetorical pyrotechnics to persuade you further of the debilitating and handicapping effects of communicative disorders on the psychosocial and intellectual development of children and on the economic and personal life of young adults and senior citizens. I doubt that anyone will argue about the value of therapeutic services, but the core of the problem lies in the lack of sufficient funds to carry out various aspects of a comprehensive program of speech habilitation and rehabilitation. School boards cannot always find the money to make speech therapy services available to their children; adequate space and facilities for speech therapy are not always included in planning for school and rehabilitation centers since costs are critical; therapists with limited or substandard training cannot afford to go back to college for advanced training because of high tuition fees; and graduate programs cannot maintain small classes for those who do go back to school since the colleges depend on a high student to professor ratio.

We at Montclair State College are concerned with the training of undergraduate students who want to teach speech. We believe in providing a program that is broad in scope and rich in professional laboratory experiences. Our basic philosophy is that all children need the services of a speech specialist—ranging from an enrichment and prevention program to a remedial program. We feel that a blending of the speech arts and sciences, in proper proportions, prepares a young man or woman to best meet the needs of all schoolchildren and to work successfully in enlisting the aid of classroom teachers. Training on the graduate level, however, is training-in-depth. Graduate students may enroll in a program leading to advanced clinical certification in speech and be prepared for the position of speech pathologist and for supervisor of speech services.

We also maintain a demonstration Speech and Hearing Center at the college and have an enrollment of approximately 100 children. We maintain affiliations with the Rehabilitation Department at Mountainside Hospital and with the North Jersey Training School (for mentally retarded girls).

We provide consultation services to the schools in neighboring communities and have conducted surveys of the speech needs of 17 school systems in New Jersey during the past 8 years.

It is within this framework of experience and interest that I should like to present some of the needs and problem areas with which we are concerned at Montclair State College.

BASIC STATISTICS IN NEW JERSEY

It is estimated that 75,000 schoolchildren have speech problems. Approximately 10,000 children are now receiving therapy in school programs.

New Jersey records indicate that in total there are 59 full-time and 15 part-time "teachers of the speech defective."

In order to service the remaining number, approximately 650 speech pathologists are needed for schoolchildren in regular classes and children in classes for the mentally retarded.

Out of some 600 school districts in New Jersey, only 25 employ 1 or more full-time teachers of speech. Of the 74 speech correctionists, 14 have only emergency endorsements.

In addition, most correction work at the moment is located in northern New Jersey. As low as the numbers are, speech correction is practically unheard of in very rural areas in the southern part of the State.

COLLEGE TRAINING PROGRAMS

Montclair State College has State and administration support in its program for preparing students as teachers of children and adults with speech disorders. The extent of the support, however, is financially limited. At the present time, we have the largest number of students enrolled in the speech major of any college in New Jersey and we still cannot fill the large number of employer requests for trained speech personnel.

We need support in recruiting larger numbers of capable young people to the profession through publications, career clinics, institutes, etc. Few high school students today are aware of speech rehabilitation as a profession. We also need to attract more men to the profession to minimize the turnover that we have because there are so many women doing special therapy work.

With an increased student enrollment, present facilities become inadequate. Federal assistance to the State may be needed to help establish comprehensive education clinics in which many disciplines are coordinated and all future teachers and specialists may observe and participate.

In addition to inadequacy of facilities with expansion, adequate supervision becomes imperative and costly. Ideally, no student clinician should provide therapy without direct supervision. This is inconceivable in assigning the 15 semester hour teaching load of a college professor. If Federal funds were available for such purposes, practicing speech pathologists could be retained on an adjunct staff appointment to help supervise the very important clinical internship experience of the college students. At present, supervision is on the basis of 5 students to 1 supervisor, whereas we feel it should be on a 1-to-1 basis while the student fulfills his prescribed 200 clock hours of clinical experience.

On the graduate level, the problem of supervision also obtains. In addition, there is the very real problem of college finances. In the State of New Jersey, graduate study at the State colleges must "pay its own way." It cannot be a losing proposition since there are no State funds to subsidize the programs. Consequently, the average class size must be 22 students, and no fewer than 15. It is virtually impossible to consistently meet this requirement in the speech major. When a program is just getting started, numbers are bound to be low. Requirements for matriculation for the master's degree cannot be met in many instances, and we are dealing with a field in which there exists a critical shortage of personnel to begin with. Therefore, a very respectable class size for a graduate speech program would be between 7 and 10 students. Unfortunately the college cannot support this, and as a result the course is canceled and as many as 10 potential speech pathologists are denied the training they must and should have. Federal aid to colleges instituting graduate programs would be tremendously valuable. We are also very much in favor of House Joint Resolution 494 as one possible solution to this problem because it may make it possible to recruit a greater number of capable students who could not otherwise afford the tuition costs.

THE SPEECH AND HEARING CENTER

Because of the shortage of trained personnel and the resulting dearth of speech programs in the schools of New Jersey, the Montclair Speech and Hearing Center has accepted over 100 students each year for free speech therapy. Free diagnostic services are also made available to approximately 200 persons each year. A minimum amount of program time has been allowed our faculty members for participation in these activities. The numbers, in proportion to personnel, are overwhelming. We are losing sight of our original purpose as a teaching and demonstration center, with service to the child in the community becoming the primary rather than secondary purpose. We are overloaded with children who have no other resource available to them in their public school or parochial school or in their community. This situation will be revised when there are a sufficient number of speech pathologists and a sufficient number of school programs.

Additional Federal funds might also make it possible to retain a supervising speech pathologist at special centers and hospitals affiliated with the college's training program.

SURVEYS CONDUCTED BY THE SPEECH DEPARTMENT AT MONTCLAIR STATE COLLEGE

The attached report summarizes the results of surveys conducted in 17 school systems in New Jersey. In order to determine the speech needs of the children enrolled, almost 25,000 children were individually tested. The final figures may be affected by (a) the lack of standardized testing criteria, (b) the occasional listing of minor problems as major ones and (c) the limited experience of the examiners. The average percentage of children needing remedial speech therapy is a good deal higher than the 5 percent figure generally accepted for the Nation. It is our feeling, however, that the 21 percent figure is fairly reliable because of the consistency with which this incidence occurred even though there were different teams of raters on almost each survey. It is not surprising to us that the incidence of speech problems in a metropolitan, overcrowded area should be higher than the average figure based on the national picture. Parenthetically, it is interesting to note that the estimated need of over 600 speech therapists is based on the 5 percent and not the 20 percent figure.

SPECIAL GROUPS

In addition to the speech-handicapped schoolchildren, there are some children and adults who invariably require speech therapy services. These persons comprise two groups:

1. The markedly atypical child with multiple disorders (mentally retarded, cerebral palsied, childhood schizophrenics).
2. The geriatric patient with chronic diseases (cerebral vascular accidents, Parkinson's disease, laryngectomy).

Research needs in these areas are great and with the rapidly increasing aged population, geriatrics will soon become the Nation's primary health problem. There is a direct relationship between chronic diseases in the aged and speech and hearing problems. Frequently, the successful vocational rehabilitation and the ability for an older person to maintain his independence and dignity depend upon the patient's ability to communicate his thoughts, wants, and needs.

With an increased population of older persons, there will be a concomitant increase in the need for trained speech pathologists and audiologists.

Under existing legislation for hospitals and rehabilitation centers, adequate speech and hearing facilities should also be encouraged in planning treatment areas. Most of the time, speech therapy facilities are substandard even in the newest installations despite the fact that of all the therapies—physical, occupational, vocational, etc.—speech and hearing therapy has the greatest potential for supporting its own program. Federal advisers to hospitals receiving grants should encourage the allocation of space that is large enough for individual and group therapy sessions.

CONCLUSION

On behalf of the members of the speech department at Montclair State College, thank you for inviting me to elaborate our needs and problems. We strongly urge the passage of the pending legislation and hope that in the near future students and speech-handicapped citizens in New Jersey may be beneficiaries of your very significant proposals.

Schools surveyed—1952 through 1965—Montclair State College Speech Department

School	Year	Grades	Total	Adequate		Improvement needed		Remedial	
				Number	Per-cent	Number	Per-cent	Number	Per-cent
Chatham Township	1957	K through 8	856	228	27	437	51	191	22
East Rutherford	1958	K through 12	1,564	478	31	786	50	300	19
Hanover Park High School	1957	9 through 11	486	94	19	333	69	59	12
Highland Park	1958	K through 8	952	357	37	378	40	217	23
North Arlington	1959	K through 8	1,122	217	19	607	54	298	26
North Haledon	1955	K through 8	560	135	24	323	58	102	18
Parsippany	1954	K through 8	1,560	498	32	732	47	330	21
Pompton Lakes	1956	K through 12	1,613	506	29	835	54	272	17
Rockaway	1955	K through 6	275	90	33	137	50	48	17
Saddle Brook	1957	K through 8	1,564	592	38	653	42	319	20
Sussex County	1952	K, 2, 4, 6, 8, 10, 12	2,273	396	18	1,280	57	597	25
Totowa	1958	K through 8	1,269	328	26	636	50	305	24
Wanaque	1957	K through 9	964	263	27	470	49	231	24
Warren County	1956	K through 8	3,487	1,096	31	1,735	50	656	19
West Caldwell	1959	K through 6	1,392	291	21	684	49	417	30
West Orange	1955	K through 6	3,257	1,153	35	1,156	48	548	17
West Orange	1957	9, 10, 11, 12	1,400	366	26	827	59	207	15
Grand totals			24,594	7,088	29	12,409	50	5,097	21

Mr. ELLIOTT. Our next witness is Mr. Charles A. Abel, of the Maryland Society for Mentally Retarded Children, Inc.

Mr. Abel, we are happy to have you here. You may proceed.

STATEMENT OF CHARLES A. ABEL, LEGISLATIVE CHAIRMAN, MARYLAND SOCIETY FOR MENTALLY RETARDED CHILDREN, INC.

Mr. ABEL. Thank you. Mr. Chairman and distinguished members of the committee, first I would like to thank you, the chairman, and this committee, for giving me the privilege of testifying in behalf of the mentally retarded children and young adults of the State of Maryland.

Mr. ELLIOTT. Thank you for being so patient with us.

Mr. ABEL. I will take this opportunity to present to you the facts which exist in this area of handicapped in our State.

In the year of 1951 with the full cooperation of the State board of education and the complete understanding of our legislative members an amendment was adopted to extend school aid to severely retarded children.

I might add that in 1956 this was extended down to the preschool handicapped children. It does not encompass the normal child, but does encompass the severely retarded child.

Some of the normal children do have preschool training in some of the counties and in Baltimore City. This mandatory legislation to our knowledge, was the first to be enacted by any State in the country pertaining to the so-called trainable retarded child.

Now, I would like to bring to your attention some positive facts which I feel relate to title II of H.R. 3465, independent living rehabilitation services.

In October of 1952 the Greater Baltimore chapter of the Maryland Society for Mentally Retarded Children, Inc., a parent group, initiated

a preschool training center, and there we hoped to prove that if these children started on a training program at an early age they could be advanced to a special education class with less difficulty.

Here we were also successful in obtaining the services of the supervisor to special education who counseled and lectured in parent education.

By September of 1954, we expanded our services to include those school age mentally retarded children who could not qualify for existing special classes. In this particular situation we were handling the blind retarded and some deaf retarded.

As a result we helped to give some counseling to the Maryland School for the Blind in handling the preschool blind retarded child.

As a result of this program we proved that these multiple handicapped children benefited from group training in small classes. After 7 years of demonstration of this project we have expanded from one class of 10 children to 10 classes of 102.

Scores of applications have been filed on our waiting lists. Of course, this does not take into account many children whose parents have not yet applied.

Federal participation that is suggested in title II of H.R. 3465 is the only hope we can see in bringing services to those who need them so desperately. By bringing these facts to your attention we feel we have concrete evidence that if this program were not in existence, many of these children being served would likely be in an institution.

This, of course, would cost $2\frac{1}{2}$ times more and would not give these children an opportunity to develop to their fullest potential.

Of these children, many have been transferred from this training program to a special class in one of the schools made available by special education. In years to come they may be able to participate in a workshop environment and possibly find their places in private industry.

This would give them the opportunity to liquidate the investment made in this behalf and achieve status within the community to the best of their ability.

The greatest need as we see it, is the lack of funds to expand these services.

I might point out that this demonstration relates to the metropolitan area and without Federal funds could not possibly be extended to our rural sections where the instances of retardation are great.

If you are not familiar with the State of Maryland, Baltimore City and Baltimore County constitute almost one-half of the population of the State. Therefore, I feel that with Federal aid we could substantially reduce the number of referrals of these children to institutions.

As we all know, maintaining an institutional program for these individuals is far more costly.

Now, if I may, I would like to show how I was able to substantiate my statement of liquidating the investment made in these children relating to title IV of H.R. 3465, in which you propose to make available funds to set up rehabilitation and evaluation services.

On September 16, 1957, a sheltered workshop was established in the Greater Baltimore area. Here we were able to bring those young

adults who had completed their training in classes of special education for the retarded. After 2 years of operation of this workshop we have been able to place in private industry 17 of these clients out of 97 who have been served.

With the aid of contract from various manufacturing establishments all of our clients who have completed their evaluation and training periods sponsored by the Department of Vocational Rehabilitation, are participating in Federal and State taxes, as well as the social security program. Although not contributing as much as those placed in outside jobs, they swell the population of tax-paying citizens.

I will submit to you in my report our report to the Office of Vocational Rehabilitation, Department of Health, Education, and Welfare, and I would like to just take one moment to give you an idea of the type of people that we are handling.

Just 4 years ago at a Texas convention of the National Association of Retarded Children, I was told that to the knowledge of the gentleman leading the discussion he had no knowledge at all of people who were of a trainable IQ level that was doing work in the area of private industry.

I might say that in the 17 who have been placed some of them range in IQs down as low as 41.

Now, you will see this in the report that I am submitting to you as our progress report.

The adoption of 3465 would give services to those who after application and evaluation could not qualify for the sheltered workshop, but who have more limited ability, would be acceptable in a center where they could be productive and retain their dignity.

In closing I would like to bring to your attention that we are not asking for the impossible. We are only requesting the rights of these mentally retarded individuals who cannot speak for themselves, but who with your help may attain a place in the community with dignity and self-confidence.

Thank you.

Mr. ELLIOTT. Thank you very much.

(The formal statement of Mr. Abel follows:)

STATEMENT OF CHARLES E. ABEL, LEGISLATIVE CHAIRMAN, MARYLAND SOCIETY FOR MENTALLY RETARDED CHILDREN, INC.

Mr. Chairman, distinguished members of the committee, first, I would like to thank you, the chairman and this committee, for giving me the privilege of testifying in behalf of the mentally retarded children and young adults of the State of Maryland.

I will take this opportunity to present to you the facts which exist in this area of handicap in our State.

In the year 1951, with the full cooperation of the State Board of Education and the complete understanding of our legislative members, an amendment was adopted to extend school aid to severely retarded children.

This mandatory legislation, to our knowledge, was the first to be enacted by any State in this country, pertaining to the so-called trainable retarded child.

Now, I would like to bring to your attention some positive facts which I feel relate to title II of H.R. 3465 Independent Living Rehabilitation Services.

In October of 1952, The Greater Baltimore Chapter of the Maryland Society for Mentally Retarded Children, Inc., a parent group, initiated a preschool training center. There we hoped to prove that if these children started on a training program at an early age, they could be advanced to a special education class with less difficulty. Here, we were also successful in obtaining the services of

the supervisor of special education, who counseled and lectured in parent education.

By September of 1954, we expanded our services to include those school age mentally retarded children who could not qualify for existing special classes.

As a result of this program, we proved that these multiple handicapped children benefited from group training in small classes.

After 7 years of demonstration of this project, we have expanded from 1 class of 10 children to 10 classes of 102. Scores of applications have been filed on our waiting list. Of course, this does not take into account the many children, whose parents have not yet applied. Federal participation that is suggested in title II of H.R. 3465 is the only hope we can see in bringing services to those who need them so desperately.

By bringing these facts to your attention, we feel we have concrete evidence that if this program were not in existence, many of these children being served would likely be in institutions. This placement, of course, would cost some 2½ times more, and would not give these children the opportunity to develop to their fullest potential.

Many of these children have been transferred from this training program to a special class in one of the schools made available by special education. In years to come, they may be able to participate in a workshop environment and possibly find their places in private industry. This would give them the opportunity to liquidate the investment made in their behalf and achieve status within the community to the best of their ability.

The greatest need as we see it is the lack of funds to expand these services. I might point out that this demonstration relates to a metropolitan area, and without Federal funds could not possibly be extended to our rural sections, where the instances of retardation are great.

Therefore, I feel that with this Federal aid, we could substantially reduce the number of referrals of these children to institutions. As we all know, maintaining an institutional program for these individuals is far more costly.

Now, if I may, I would like to show how I was able to substantiate my statement of liquidating the investment made in these children, relating to title IV of H.R. 3465, in which you propose to make available funds to set up rehabilitation evaluation services.

On September 16, 1957, a sheltered workshop was established in the Greater Baltimore area. Here we were able to bring those young adults who had completed their training in classes of special education for the retarded.

After 2 years of operation of this workshop, we have been able to place in private industry 17 of these clients out of 97 who have been served. With the aid of contracts from various manufacturing establishments, all of our clients who have completed their evaluation and training periods, sponsored by the Department of Vocational Rehabilitation, are participating in Federal and State taxes, as well as the social security program. Although not contributing as much as those placed in outside jobs, they swell the population of tax paying citizens.

I submit to you, for your examination, our progress report to the Department of Health, Education, and Welfare, to substantiate the statements of this testimony. This report is as of June 30, 1959.

The adoption of H.R. 3465, as I interpret the bill, would give services to those who after application and evaluation could not qualify for the sheltered workshop, but who have more limited ability would be acceptable in a center where they could be productive and retain their dignity.

In closing, I would like to bring to your attention that we are not asking for the impossible. We are only requesting the rights of these mentally retarded individuals who cannot speak for themselves, but who with your help may attain a place in the community with dignity and self confidence.

PREFACE

REPORT BY SHELTERED WORKSHOP, MARYLAND SOCIETY FOR MENTALLY RETARDED CHILDREN, GREATER BALTIMORE CHAPTER, INC.

The first 6 months of 1959 has been a period of broadening horizons for the Occupational Training Center for the Mentally Retarded. We are progressing toward maturity and our stature is being recognized by many of the local industrial, educational, and civil groups.

We are just beginning to explore the potentials in this field, and we have great distances to cover before this sheltered workshop will acquire a firm foundation of recognition from industry and the community at large.

In my judgment, this workshop will succeed in becoming an integral facet of community planning for rehabilitation of the mentally retarded when we have demonstrated that with proper evaluation, vocational guidance, counseling, specialized placement, and followup, there is definite hope for the mentally retarded individual.

The future of the sheltered workshop and the services to clients will depend largely upon the service we give to industry and the community.

This Office of Vocational Rehabilitation project became an integral part of the division of vocational rehabilitation of the Greater Baltimore area. It has been a significant factor in the formation of the program and plays an important part in the development of a community plan for the rehabilitation of mentally retarded adults.

REQUEST FOR CONTINUATION GRANT

Section 1. Identification

Name of grantee organization: Maryland Society for Mentally Retarded Children, Greater Baltimore Chapter, Inc.

Title of project: "Occupational Training Center for the Mentally Retarded."

Selected demonstration project: R.D. 373.

Section 2. Background

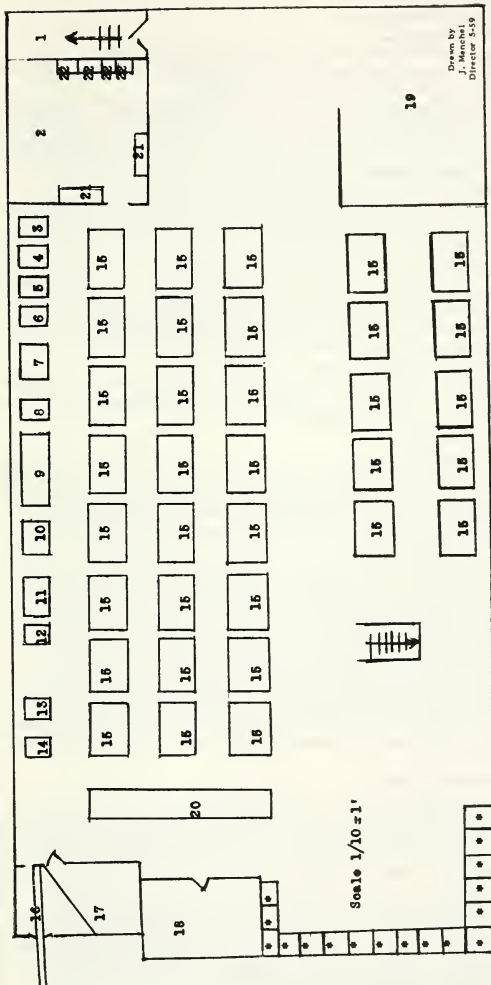
On September 16, 1957, the sheltered workshop for the retarded was established at 2438 Greenmount Avenue, Baltimore 18, Md., with the strong cooperative efforts of the division of vocational rehabilitation. It was set up because Maryland had no other agency to evaluate the vocational potential of the retarded, and also to provide a place for those who could not meet the requirements of outside competition.

On January 1, 1959, the Office of Vocational Rehabilitation approved a selected demonstration project grant to the sheltered workshop entitled, "Occupational Training Center for the Mentally Retarded." The purposes of this demonstration project are:

1. To provide a period of evaluation followed by transitional, as well as long-range, sheltered work experiences through the use of knowledge, methods, and techniques acquired through the Office of Vocational Rehabilitation and the prototype project in New York City.
2. To demonstrate the effectiveness of vocational rehabilitation services.
3. To increase the employability of the retarded young adults who were formerly considered unemployable.
4. To provide a year-round industrial environment which will permit the evaluation to work capacity, and which will develop a work personality in the retarded adult.
5. To educate the community so it will have a better understanding of the mentally retarded adult and the value of rehabilitation services.

Section 3. Referrals

The referral procedure established is that all referrals will come from the division of vocational rehabilitation.



Legend

- | | | | | |
|---------------------|----------------------|---------------------|------------------------------|-----------------------|
| 1. Fire escape | 2. Office | 3. Sewing machine | 4. Multilith | 5. Mimeograph |
| 6. Laminating Press | 7. Table Drill Press | 8. Punch Press | 9. Multi spindle Drill Press | 10. Floor Drill Press |
| 11. Hydraulic Press | 12. Band saw | 13. Coke Machine | 14. Water cooler | 15. Work Tables |
| 16. Electric Hoist | 17. Ladies Rest Room | 18. Mens Rest Room | 19. Storage Area | 20. Lunch Tables |
| 21. Desks | 22. File Cabinets | * Clothing Lockers. | | |

Section 4. Intake procedure

An intake policy was established to include the work capacities of the mentally retarded regardless of concomittant disabilities:

1. No individual with an IQ over 75.
2. Seizures have to be under control.
3. No emotionally disturbed.
4. Each client is required to attend to his personal physical needs.

All trainees use public transportation except the mentally retarded severely orthopedic who were in the workshop prior to the grant.

Prior to admission, a complete history and profile of the applicant is obtained; psychological, vocational, and medical evaluation to determine abilities, academic achievements, social maturity, and emotional stability. The social worker visits the home and agencies to record a complete family and social history of the applicant. This gives the social worker a clear picture of the background; this knowledge is important in advising and counseling the trainee.

Since one of the functions of the training center is to introduce acceptable habits and attitudes toward work, one of the methods used is parental counseling. With the mentally retarded who has never known independence of action or judgment, it is essential that the parent be a part of the training program. The prevailing attitude at home is a profound factor influencing the individual's capacity to accept the orientation of the training program. Therefore, an established procedure is for all parents to be seen to encourage their cooperation in bringing about any needed changes. One of the aims in working closely with parents is to enable them to feel secure in permitting their child to achieve a greater measure of independence.

For those who are rejected, possible alternate plans are explored. For those accepted, a tentative program plan outlining approaches in training and development of vocational and social skills are formulated.

Section 5. Prevocational evaluation

Upon admission, the client is assigned to the prevocational evaluation area for a period of 6 weeks. To obtain an objective evaluation, each individual tries out many industrial tasks requiring various degrees of skill. The clients are rated on the basis of what industry requires of employees doing the same job.

As the client goes from one task to the other, comments are recorded concerning the work habits, work tolerance, social relationships, and emotional stability. Close supervision is maintained on all clients and reason for failure is noted. The purpose of this evaluation is to determine what is the maximum each individual can do; not what he cannot do. When we know what can be done, we have a point of departure for further investigation into vocational areas for possible placement into outside competitive industry.

During the 6 weeks evaluation, a client has the opportunity to manipulate tools and machines on jobs about which he had no previous knowledge.

Counseling varies according to the needs of each client. The majority of the applicants have never held jobs before and require intensive vocational orientation and guidance. Still others, who have lived isolated and protected lives, must first learn compatibility with others and gain a realistic view of their limitations and goals.

Section 6. Personal adjustment training

Personal adjustment training means the individual's ability to be trained in order to meet all the qualifications demanded for occupational employment and successful job holding. This means ability to meet the maximum physical demands, the intellectual needs and emotional reactions which are required. The trainees in the center are being processed to prepare themselves for useful employment.

When the client completes his evaluation and enters this training phase, he is taught the proper way to do his job. The training personnel are both able and willing to explain the approved method, are patient while these methods are being understood and followed. Considerable energy is devoted to the encouragement of the trainees during those periods in the learning process when little or no improvement or accomplishment seems apparent.

Since understanding is so important for learning, all trainees receive both oral instructions and actual practice. Explanations are given to help them clarify or understand the methods to be learned, and then the actual use of the learning to make the understanding complete. The final stages of understanding thus come with actual practice.

The fact that a client does not rate high in ability to learn quickly, or that he has no special aptitude for training center jobs, does not mean that he can be left without training. Every client is given appropriate training. Trainees who stand at different levels of ability and aptitude are trained for different types of jobs. (See sec. 12, 13, and 14.)

The instruction is kept lively by being made immediately practical. It is necessary that the trainee understand basic principles if he is to be most efficient, but instruction in basic principles are kept near enough to practice for the application to be apparent. Omitted from the instruction is theory that is irrelevant or remote.

An all-around approach is the method used by the supervisors. Every possible way of reaching the trainee's mind is used: Oral instructions, demonstrations, visual aids, and counseling. Instruction is put to immediate use by action on the job.

The supervisors are guided in developing the training program through the use of a simple formula which was developed by Dr. Charles R. Allen and Dr. Charles R. Richards, and the U.S. Office of Education.

The form in which the formula is generally accepted and used now is:

$$E=M+T+I+J+Mo$$

E =Personal equipment needed by the individual for job success.

M =Manipulations of hands, machines, or tools, or combination of each.

T =Technical knowledge necessary to make M operative.

I =General industrial knowledge of safety, hygiene, materials, and other items which contribute to make a workman.

J =Judgment.

Mo=Morale.

Jobs of semiskilled nature are represented as follows:

$$E=M+T+I+J+Mo$$

These are highly developed, single purpose jobs which do not require much technical or general occupational knowledge. The "J" term increases with experiences and performance and eventually becomes of equal importance with "M."

PAYMENT OF TRAINEES AND WORKERS

The primary focus is on personality development and preparation for employment. The payment of the trainees is considered as a secondary factor in the workshop. The workshop has a U.S. Department of Labor approved minimum wage of 10 cents per hour for trainees and 20 cents per hour for workers.

Workers are paid according to the number of items they produce. Payment per item is gaged according to the amount a normal person in industry produces in 1 hour, at \$1 per hour. Our workers being less productive, earn proportionately less. If a worker does not earn the minimum wage, his pay is subsidized.

Sample breakdown of subcontracts for payroll

Types of contracts	Number of pieces	Number per hour	Price	Average hourly rate
Metal shoe assembly 13.....	163,000	125	9.90M	0.21
Metal shoe assembly 17.....	48,000	125	9.90M	.22
Broadside inserting.....	16,256	100	1.80	.30
Paper wiring.....	73,200	500	2.10M	.18
Tab cutting.....	29,000	600	1.75M	.23
Brass hinge assembly.....	3,645	100	1.00	.22
Tension band assembly.....	6,240	150	1.00	.20
Stroll clamp assembly.....	2,035	200	1.00	.23
End clamp assembly.....	1,261	100	1.00	.20
Rail end assembly.....	1,750	100	1.00	.21
Gate closures drilled and assembled.....	1,018	10	1.00	.30
Metal butterfly drilling and assembly.....	1,236	70	1.00	.22
Metal butterfly ketch assembly.....	525	90	1.00	.20
2-way band assembly.....	1,827	95	1.00	.20
Fork assembly.....	509	120	1.00	.20
C/L band assembly 23.....	45,000	300	3.50M	.20
C/L band assembly 21.....	24,000	300	3.50M	.20

Section 8. Population

During the first 6 months of operation, a total of 58 clients were served in the training center and the sheltered workshop; 29 clients were carried over from a previous operation of the shop; 29 new clients were admitted since January 1, 1959; 25 clients were terminated, as follows:

Community employment	9
Referred for advanced training	8
Unable to adjust	4
Family withdrew	4

All entering trainees receive the same services of prevocational evaluation, personal adjustment training, counseling, vocational guidance and community placement, or long-term training and employment in the workshop.

Auxiliary programs include weekly recreation activities at the YWCA (swimming, basketball, dancing), monthly dance and Girl Scout troop.

Section 9. Age and sex

There have been more retarded males served in the center than females; 36 or 63 percent were males, 22 or 37 percent were females.

Age	Male	Percentage	Female	Percentage	Total number	Total percentage
16 to 17	4	6	2	4	6	10
17 to 18	9	16			9	16
18 to 19	2	4	4	6	6	10
19 to 20	3	5	3	5	6	10
20 to 21	7	12	3	5	10	17
21 to 22	3	5	3	5	6	10
22 to 23	3	5	4	6	7	11
23 to 24	1	2			1	2
24 to 25	1	2			1	2
25 to 26	1	2			1	2
26 to 27	1	2	1	2	2	4
Over 27	1	2	2	4	3	6
Total	36	63	22	37	58	100

Section 10. Distribution of intellectual levels

Intelligence of trainees based on IQ scores ranged from 30 to 75. For this purpose, either the full-scale Wechsler IQ, or the Stanford-Binet IQ was taken, depending which was available, reliable, and most recent.

IQ	Male	Percentage	Female	Percentage	Total number	Total percentage
30 to 34	4	7	1	2	5	9
35 to 39	1	2	1	2	2	4
40 to 44	5	8	2	4	7	12
45 to 49	4	7	3	5	7	12
50 to 54	1	2	7	12	8	14
55 to 59	6	10	1	2	7	12
60 to 64	6	10	1	2	7	12
65 to 69	6	10	3	5	9	15
70 to 75	3	5	3	5	6	10
Total	36	61	22	39	58	100

Section 11. Concomitant disabilities

Concomitant disabilities found included speech problems, cerebral palsy, et cetera. The table below gives the concomitant disability, the number of trainees involved, and the percentage.

Disability	Number of clients	Percentage
Speech.....	34	59
Epilepsy.....	12	21
Vision.....	10	17
Emotionally disturbed.....	8	14
Orthopedic.....	6	10
Cerebral palsy.....	5	9
Hearing.....	4	7
Polio.....	2	3
Aphasic.....	2	3
Cardiac.....	1	2
Parkinson disease.....	1	2

Section 12. Placement

Placement is a function of the division of vocational rehabilitation within the program of this project. It is the responsibility of the rehabilitation counselors, in cooperation with the project director and supervisors of the project, to see that the trainees of the project are placed in the labor market for which they have been prepared. The ability to place those who have participated in pre-employment training, in the jobs for which they have been trained, is the supreme test of effectiveness of the training and the acceptance of the training programs by employers.

Since January 1, 1959, nine trainees have been placed in community employment.

Type of job	Number of clients	Age	IQ
Repair shop helper.....	1	20	49
Sewing machine operator.....	1	17	50
Distributing circulars.....	4	20-22	55-64
Sander.....	1	20	59
Housecleaner.....	1	17	68
School aid.....	1	23	71

Section 13. Pending placement

Eleven trainees are in this group.

Type of job	Number of clients	Age	IQ
Dishwasher.....	1	18	41
Baker's helper.....	2	16-20	47-75
Janitor's helper.....	2	16-20	40-64
Floor boy or lady.....	3	19-23	50-59-67
Stripper.....	1	17	63
Opaquer.....	1	17	65
File clerk.....	1	21	67

Section 14. Referred to other agencies for training

Type of training	Number of clients	Age	IQ
Sewing machine operator.....	5	16-20	46-71
Tile setter.....	2	17-21	58-67
Truck driver's helper.....	1	20	57

Section 15. Information and community education

The work of the special demonstration project has been widely publicized through speeches, publications and personal visits to professional organizations. There has been a steady stream of visitors from all parts of the country to see the project.

Speeches :

The Industrial Club of Baltimore, Md.
 Division of Vocational Rehabilitation Counselors Staff Meeting.
 Kiwanis Club of Sparrows Point.
 Maryland State National Rehabilitation Association.
 Anne Arundel County Association for Mentally Retarded.
 St. Agnes Hospital Student Nurses.

Publications :

"M. R. C. Shop Explores New Job Possibilities," Children Limited, April 1959.
 "Prevocational Evaluation in an Occupational Training Center," Training School Bulletin (Pending).
 "Prevocational Evaluation in a Workshop for the Retarded," Council for Exceptional Children (Pending).
 "Sheltered Workshop," the Marylander Teacher (Pending).
 "The Making of Contacts," Journal of Rehabilitation (Pending).
 "Job Analysis for Prevocational Evaluators," Vocational Guidance Quarterly (Pending).

Section 16. Plans

As a result of our observations, records and experiences during this short 6 months period, we are able to see promise of worthwhile results, and some indication of favorable paths to follow in the vocational rehabilitation of the mentally retarded.

During the period from January 1, 1960, to December 31, 1960, for which continuation grant funds are being sought, the following plans have been formulated :

1. To expand training in trade and industrial manipulative skills, which are needed for successful entrance into trade and industrial employment.

2. To expand the evaluation phase in nonmanual aims :

A. To provide those valuable developmental experiences associated with learning through doing, through sense of touch or feeling in combination with other senses.

B. To provide opportunities for significant experiences in thought and performance through individual and group tasks.

C. To develop knowledge and appreciation of materials, products and tools of modern industry.

3. To further study and the removal of the element of fear in the use, adjustment and repair of mechanical-electrical devices common to every day industry.

4. To further the development of work habits and attitudes which are needed for obtaining a job and also for the holding of a job.

5. To further explore the use of community resources to help create public awareness of the mentally retarded's needs and problems, and to raise the level of civic participation.

Mr. ELLIOTT. Our next witness is Mrs. Mirian Tannhauser, State chairman of special education for the Maryland Congress of Parents and Teachers, of Baltimore, Md.

You, too, have been very patient, Mrs. Tannhauser. We bespeak our appreciation to you.

**STATEMENT OF MRS. MIRIAN TANNHAUSER, STATE CHAIRMAN,
 SPECIAL EDUCATION FOR THE MARYLAND CONGRESS OF
 PARENTS AND TEACHERS, OF BALTIMORE, MD.**

Mrs. TANNHAUSER. I am State chairman of special education for the Maryland Congress of Parents and Teachers, representing over 200,000 members in 700 local communities.

Our concern is for the health, education, and welfare of all children.

Today I speak to you particularly in behalf of 80,000 children in Maryland with special needs.

The Maryland congress endorses the legislative program of the National Congress of Parents and Teachers. Copies of the national

program and adopted State program for legislation are provided for your information.

I refer to item IV, page 2, of the State program to show our continuing interest in Federal aid for education. Item V on pages 2 and 3 point up specific areas of concern for children with special needs.

Pages 4, 5, and 6 of this report support needs of children in general, but are of special importance for children with special problems.

H.R. 3465, the independent living bill, and House Joint Resolution 494 training of teachers, speech pathologists, and audiologists, are in line with the interests and purposes of the Maryland Congress of Parents and Teachers. I, therefore, speak in support of these bills.

Representatives from Maryland State governmental departments will have spoken of State programs and special needs. The Maryland Congress of Parents and Teachers cooperates with these departments by supporting the best possible services for all children.¹

Support of major functions of government in Maryland is provided:

Mental hygiene: local, none; State, 100 percent; Federal, none.

Highways: local, 3 percent; State, 76 percent; Federal, 21 percent.

Welfare: local, 21 percent; State, 33 percent; Federal, 46 percent.

Correction: local, 28 percent; State, 72 percent; Federal, none.

Health:² local, 33 percent; State, 55 percent; Federal, 12 percent.

The 1958 per capita income in Maryland was \$2,221, thus ranking Maryland 10th among the States. The State ranked 37th, however, in per capita State expenditures for education.

We ranked 18th in estimated current expense per pupil in 1958-59.

We ranked 26th in percent of revenue for public elementary and secondary schools from State government in 1957-58.

We ranked 35th in State tax revenue as a percent of personal income payment, with only 4 percent of personal income going for State taxes.

The PTA feels that a greater portion of our Nation's tax resources at State and Federal level must be used to provide the kind of education and training which will develop our greatest resource, our children, more effectively.³

Local school systems have traditionally and should continue to provide the major share of the responsibility and the control of education. Equalization formulas are used in many States, however, to assist local school systems. Could not such an equalization system on a broader base provide assistance from and to the Nation as a whole?

The education and training of handicapped children in a school system where the annual operating per pupil cost is \$434 for normal children, it is approximately \$1,000 for a handicapped child.

In a school system where the capital cost for each new elementary student is approximately \$1,140 and for each new secondary student \$2,400, it will cost \$3,700 per handicapped child who requires special physical facilities.

School systems in sparsely populated areas have many practical problems in trying to set up adequate special education programs.

¹ Total pupils in public school in Maryland, kindergarten through 12th grade, 665,963; 12 percent of these children will need special services—92d Annual Report of State Board of Education, 1958. Fiscal research bureau, 1957-58.

² Exclusive of University of Maryland Hospital.

³ Maryland State Teachers Association.

Many local school systems do not have the resources to support special education. Other systems with greater wealth are confronted with school population increases of 169 percent ⁴ in 10 years.

The Nation cannot afford the human waste, nor can it afford to provide for 5,160,000 ⁵ nonproductive citizens.

In an address to the National Association for Retarded Children in 1957, Miss Mary Switzer, the Director of the Office of Vocational Rehabilitation of the Health, Education, and Welfare Department, reported that of 756 retarded people given vocational rehabilitation training in a pilot project in 1956, their combined earnings rose from \$32,100 annually to \$1,265,150 annually. This demonstrates an increase of 40 times and returned in taxable income more than the cost of the training program for the first year.

I have called attention to the interest and efforts of the Maryland Congress of Parents and Teachers in behalf of the health, education, and welfare of all children and of children with special needs in particular.

I have cited the source of support for major functions of the government of Maryland and supported the need for increased State and Federal aid for children with special needs.

Now, I have a specific proposal for your consideration. This proposal is in line with the policies and purposes of the Congress of Parents and Teachers, but has not yet been presented for their official consideration.

This proposal is made as a result of my professional interest after 20 years of work in this field and recent endeavors in educational research.

I propose the establishment of a national institute of education research. At the present time the challenge to keep abreast of the new concepts concerning processes and problems of growth, maturation and brain physiology is as stimulating as it is time consuming.

Even if one could give full time to factfinding in these three areas alone, the job of interpretation and integration of the new concepts and insight into our educational philosophy would remain in insurmountable task.

When we add to that task the need for educators to alert themselves to the findings of the more technical disciplines such as neurophysiology, biochemistry, and neuropsychiatry, audiology, psychology, and anatomy, most school people feel hopeless and frustrated.

A second problem exists within the field of education itself. By what means and through what channels can school systems, educators and teachers establish a clearinghouse where current educational problems and needs would be matched with existing resources on a nationwide basis.

At no time in the history of this country's educational history and philosophy has this need for pooling of up-to-the-minute information on resources and needs been so great or so urgent. Neither have the results of not having provided the necessary policies and procedures to implement an information exchange service, been so disastrous to our professional morale and educational efficiency.

⁴ Montgomery County, Md., 1950-60.

⁵ U.S. Office of Education, Division of Exceptional Children.

Why, for example, should not school system X which plans on starting a program of emotionally disturbed children next fall, not be able to write to an educational clearinghouse and receive an accumulative file reporting on educational programs for emotionally disturbed children, thus being able to profit by the experience of other school systems and avoid, at least the major mistakes they have made.

Mortimer J. Adler, in a recent report, while not referring directly to this specific problem, does describe what he feels is essential if we, as a nation, are to cease being a country which fails to honor knowledge.

We need—

he says—

to reorganize and reorient our whole system; to educate our teachers as few are now educated; to invent materials and techniques of teaching which do not now exist, and to devise graded courses of study which are designed to do for every level of ability exactly what the traditional liberal curriculum once did effectively (during colonial times) for the few and most gifted children.

Dr. Adler is describing what we need to do. I am suggesting that the way in which this need can be resolved is to establish on a permanent long-term basis a National Institute of Educational Research.

We need to reexamine our instructional technique and our concept of how to help these children learn which our investment in medical research have saved.

Is it not important now that we have made life and health for hundreds of thousands of additional children that we not invest in finding how to make that life worthwhile to them?

Federal legislation and appropriation during these recent years have encouraged educational research and the training of personnel for leadership positions.

I cite, however, that many public school systems have been deterred from actual research by the lack of personnel and facilities in the universities and State departments to head the educational research.

I am also concerned that the scholarships in our State which are afforded to the State board of education have not even been requested because those persons who would profit and for whom they were intended cannot afford to give up their positions for \$2,000 a year.

Federal legislation has helped. We ask that you consider a National Institute of Educational Research as another step, as a centralizing and organizing means, stemming from some of the things we are doing.

Experiments in education could be correlated with medical findings at national level, at the very time that the medical investigation is determining how this child brain or body works.

New techniques which are needed, new machines, new methods, new materials, could be tested. Research fellowships could be provided to give opportunities for personnel from these State departments and universities to work out local problems, to learn research techniques, to try out the effectiveness of equipment, before it is reproduced in the various States.

Internships then could be available in all the centers where research would be done more effectively as a result of this training period in a National Institute of Educational Research.

Standards of excellency in all education could be tried, tested, and proven.

Education and training to the maximum development of the potentiality and social usefulness for all children, regardless of race, creed, or ability, is the thing we all believe in, but have never provided for.

Can we not strengthen the hope, the integrity, and the future of our Nation through a National Institute of Educational Research, which would demonstrate that our Nation does honor education and provides for its development.

Thank you.

Mr. ELLIOTT. Thank you very much, Mrs. Tannhauser, for your statement.

(Document attached to Mrs. Tannhauser's statement follows:)

PROGRAM OF MARYLAND CONGRESS OF PARENTS AND TEACHERS

This program is set up in two sections: "We actively support" and "We endorse," plus a few recommendations to the State board of education and to county councils.

EDUCATION MUST PRECEDE, ACCOMPANY, AND FOLLOW LEGISLATION IF ANY IS TO SUCCEED

This we believe:

"All we want for children and youth has its roots in the moral and spiritual values we cherish. We hear a great deal about standards of living, but what we want for our children—and what they want for themselves—is a standard of values. Today, as at no other time in history, we feel the need for this sturdy morality and firm spiritual strength.

"No social invention however ingenious, no improvements in government structure however prudent, no enactment of statutes and ordinances however lofty their aims, can produce a good and secure society if personal integrity, honesty, and self-discipline are lacking" (from "Moral and Spiritual Education in Home, School and Community," by the National Congress of Parents and Teachers).

PROGRAM FOR LEGISLATION

We actively support:

I. IMPROVEMENT OF TEACHER TRAINING

A. *In State-supported teachers' colleges.*—

1. Adequate salaries for faculties: We urge that the Governor adopt the salary scale fixed by the State board of education in accordance with the provision of article No. 77, public school laws of Maryland.

We urge PTA local units, councils, and all citizens interested in public education to communicate to the Governor the urgency for elevating salary scales for teachers in State-supported teachers' colleges to levels deemed adequate by the State board of education and comparable to those of other public institutions of higher learning in the State.

2. Expansion of facilities: For the last 5 to 7 years the legislative appropriations have been less than half of the amount recommended by the State board of education as being urgent to meet the greatly increasing needs. Therefore, we urge the Governor and Maryland General Assembly during its 1960 session to provide the full appropriation of \$3,556,500 as requested by the State board of education. These funds would permit the continuation of the current program pending the final adoption of the proposed long-range building program of which this is a part.

B. *College of Education, University of Maryland.*—Adequate financial support should be provided, with particular emphasis on new building facilities, to meet the needs of the rapidly expanding enrollments of both graduate and undergraduate students.

C. *Morgan State College.*—An appropriation sufficient to meet the tremendous need here for increased faculty salaries for the teacher education program.

D. *Scholarships*.—We commend the Maryland General Assembly for authorizing (by House Joint Resolution 6) the appointment of a special commission to study the whole scholarship program. We further commend this commission for their diligent study and efforts in developing a plan which accomplishes the charge of the general assembly. We are extremely disturbed at the action of the legislative council, which on November 4, 1959, voted to defer action until 1961. In view of the fact that this is the fifth study in 39 years without a thorough revision of the hodgepodge method of awarding State scholarships, we strongly urge the general assembly to enact a law in the 1960 session which provides to the State and the recipients the maximum benefits and usefulness of moneys appropriated for this purpose.

II. BETTER QUALITY OF EDUCATION

A. *Teachers' salaries*.—To attain continuing improvement in the quality of education it is necessary that teachers be compensated adequately. We propose a State minimum-salary scale of \$4,000 to \$6,000 for all teachers holding at least a bachelor's degree, a State minimum-salary scale of \$3,800 to \$5,800 for all teachers holding a regular first grade or higher certificate, and a State minimum-salary scale of \$3,500 to \$5,400 for all teachers holding a nondegree emergency certificate, to be provided by the general assembly at its 1960 session. These scales are the same as we proposed previously, and are urgently needed now.

NOTE.—The delegate body at the 1959 convention passed a motion voicing its opposition to the inadequacy of the report issued by the James committee on taxation and fiscal matters, and further urged each delegate to inform his legislators of his opposition to the report and to reaffirm support of the above position regarding teachers' salaries.

III. ACHIEVEMENT OF ADEQUATE LIBRARY SERVICES

A. Establishment of public libraries and bookmobiles in the several counties in Maryland where such services are not now provided and the improvement and expansion of others so that every citizen in every county may have free access to good reading and information, and guidance in its use. We urge State and county responsibility for financing public library buildings. The year beginning July 1, 1960, will be the last year to receive an establishment grant, \$12,000–\$20,000, under the Maryland plan for use of the Library Services Act fund.

B. Establishment of a Graduate Library School in Maryland which will grant a master's degree in library science, in order to provide certified librarians for the public, school, college, and institution libraries of the State.

IV. FEDERAL AID FOR EDUCATION

A. Endorsement of the National Congress of Parents and Teachers program of legislation.

B. Annual renewal of certain established Federal programs:

1. Federally impacted areas: We oppose any change in the present formula for impacted areas aid and urge full appropriation of the amounts presently authorized.

2. School hot-lunch program: The continued appropriation of necessary funds for this sound and essential educational and welfare program.

3. Extend library services: The full appropriation of \$7,500,000 as provided in the Library Services Act of 1956 for this terminal legislation.

C. We urge the general assembly to enact whatever appropriation is necessary for Maryland to take full advantage of the National Defense Education Act of 1958 (Public Law 864).

V. MEASURES FOR JUVENILE PROTECTION

A. Classes for emotionally disturbed children: State aid in the same manner as now provided for the physically handicapped.

B. Increased funds for mental health services, including hygiene clinics:

1. Increased State and local funds for the promotion of community mental health services and mental hygiene clinics and the necessary supporting preventive and medical treatment services throughout the State. These noninstitutional mental health services should be immediately expanded, not only to meet the backlog of demand from schools, but also to deal effectively with the growing

trend to treat mental patients, outside institutions, in their own communities; and we support the expansion of services.

2. Expansion of services at Rosewood Training School: The acceptance of the proposed program of the State department of mental hygiene for the development of extended care and services for the mentally deficient and the emotionally disturbed children at this school. Further, we recommend the inclusion of the trainable child to a greater extent in the education program at Rosewood, and the improvement and expansion of the entire education program.

C. Adequate appropriations for the bureau of child welfare, of the State department of public welfare:

1. Detention services: We favor continued support for adequate detention facilities and services for juveniles and entirely separate from adults and separate from State training schools whose facilities are for rehabilitation and training.

2. Probation services: Adequate probation services for all juveniles needing such help and provided by fully qualified and trained probation officers, in accordance with minimum standards recommended by the State department of public welfare and the National Parole and Probation Association.

3. See other items listed in supporting data.

VI. BOARDS OF EDUCATION

We consider the composition of local boards of education and the methods of appointment or nomination to be of great importance and of statewide significance, and therefore urge PTA councils and local units to take the initiative (where board members are appointed) for calling countywide nominating conventions which would recommend only qualified and interested persons for such positions. (Request recommended procedures for this.)

NOTE.—The following item was recommitted to committee, by convention body, November 5, 1959, for study and rewording:

Safety—Driver education

We recognize the importance of driver education and its relation to safety on our highways, but we also recognize that it can interfere with the already overcrowded academic program and likewise it absorbs the already short supply of available teachers. Therefore, we recommend its implementation during other than regular academic class time.

We endorse and support such action or bills as might be introduced to achieve the following objectives, providing they are not in conflict with established PTA objectives and policies:

EDUCATION

I. CONTINUATION OF EQUALIZATION PRINCIPLE IN MARYLAND'S PUBLIC SCHOOLS

Maryland law provides that every child within the State shall be entitled to a minimum program of education regardless of where the child lives and regardless of where the wealth of the State lies. The State guarantees the minimum educational opportunities for its children with equal financial effort on the part of its political subdivisions.

A. We recommend that State financing of school operating costs which has fallen from 42 percent to a recent level of 35.6 percent be restored to approximate the national average of 45 percent.

B. The ratios of assessments to actual cash values used by the several counties and the city of Baltimore in all State-aid programs should be as closely comparable as possible. We call upon the Governor and the legislature to continue to take such joint and individual action as is necessary to achieve this purpose.

II. SCHOOL BUILDINGS

A. We reaffirm our stand that the incentive fund should be continued and increased.

B. The allocation of additional contributions should be based upon the increase in enrollments—the additional pupils for whom schools are needed.

III. TITLE TO SCHOOL PROPERTY, CONTRACT APPROVAL, AND PURCHASE OF SITES

We oppose any local bills which would transfer the title of school properties now vested in the county boards of education to county commissioners or other

local governing bodies. This applies also to approval of contracts for new school buildings, and purchase of sites. We believe that our present State and county boards of education with their vested powers serve as safeguards in keeping our schools out of partisan politics.

IV. SCHOOL SYSTEM

A. State aid should be extended to include kindergartens as well as junior colleges, and adult education should be recognized as an integral part of the system.

B. Reduction of class size to a more reasonable and educable size, in both elementary and high schools, as a means of improving the quality of education and the morale of teachers. We believe no class in elementary school should consist of more than 25 pupils, as recommended at 1958 Maryland Conference on Education.

C. Guidance and counseling: We believe guidance counselors should be employed to serve children in elementary schools as well as in secondary schools, and that the ratio of pupils to counselor in secondary schools be reduced from the present State average of 660 pupils to 1 counselor, to at most 300 pupils to 1 counselor (as recommended at Maryland Conference on Education).

D. School librarians and dietitians: We urge that qualified elementary school librarians be employed and that State aid be made available for their salaries as additional school personnel. Likewise, that qualified school dietitians be employed as rapidly as possible and made regular members of the professional staff of the schools.

JUVENILE PROTECTION

I. Adequate appropriations for the Bureau of Child Welfare, a division of the State Department of Public Welfare, so that it can continue and implement its program.

II. Juvenile courts: All juvenile courts established at the circuit court level and staffed with qualified personnel.

III. Child placement: The strengthening of present laws and adoption of others to safeguard children in cases of placement, adoption, foster care, and aid to dependent children, with appropriations to protect their living standards and provide proper services to their families; and to find a sufficient number of suitable foster homes.

IV. Standard requirements for day-care centers.

V. Narcotic control: We demand continuing adequate legislation for vigilant control of narcotics and for more stringent punishment for distributors and peddlers.

VI. The control of sex deviates, perverts, and child molesters: We demand that convicted sex deviates, perverts, and child molesters not be paroled until they have had positive treatment at a State institution set up for the rehabilitation of such persons, and in the opinion of the court, they have been adjudged by competent professional authority to be not likely to repeat this type of offense.

NOTE.—The following item was recommended to committee, by convention body, November 5, 1959, for study and rewording:

Pornographic materials, etc.: We urge the maximum penalties for persons found guilty of possessing, producing, showing, or selling obscene photographs, slides, films, literature, or other such materials. (Request NCPT report on this.)

HEALTH

I. DENTAL HYGIENE PROGRAM

A. We recommend that the Maryland State and Baltimore City Departments of Health and the health departments of the 23 counties increase their dental services to children by providing more funds for dental clinics where children unable to obtain private services may receive the necessary care.

B. We recommend that county councils and local units urge that the addition of fluoride to public water supplies to bring the fluoride concentration up to one part per million be instituted at the earliest time possible by public-water-supply authorities.

II. MIGRANT FAMILIES

We urge local PTA's and councils, in areas where migrant workers are employed, to cooperate with local and State authorities to deal with any attendant problems of health, education, safety, or welfare.

III. NURSING SERVICES

We recommend that State aid be provided to counties on a matching basis for nursing services in the public schools.

IV. SCHOOL PSYCHOLOGISTS AND PSYCHIATRISTS

We recommend county and State appropriations in order that the county boards of education employ psychologists and psychiatrists to work in cooperation with the county health departments (see also p. 3, V-B).

SAFETY

I. DRIVER LICENSES

We urge that steps be taken as rapidly as possible to assure that holders of operators' licenses for motor vehicles are entirely competent and physically fit, and that periodic examinations be required.

II. SCHOOL BUS LAWS

A. We urge the State legislature to amend section 233, article 66½ of the motor vehicle code that requires erection of signs at the State line giving a résumé of the schoolbus laws to include a requirement for similar signs at frequent intervals on those portions of all National and State highways traveled by schoolbuses.

We further urge the Maryland State Roads Commission to request such funds as are necessary from the State legislature for the erection of more schoolbus law signs, said signs to be erected at reasonable and frequent intervals on National and State routes.

B. We urge the State department of education and the State department of motor vehicles to adopt and enforce a uniform rule for the marking of all schoolbuses to include the "minimum penalty for violation of the schoolbus law" and to reevaluate the present rules and markings.

RECOMMENDATIONS TO STATE BOARD OF EDUCATION

1. Recognizing that there is nothing so important as a qualified and competent teacher in every classroom, we call upon the State board of education to eliminate "emergency certificates" as soon as, in its opinion, a sufficient number of qualified teachers are available; and that each teacher now teaching under such a certificate be required to take courses in major subjects each year (until becoming certified) in order to be retained in the State school system.

We look with disfavor on the trend, though small, of employing teachers with 2 years of college or less.

2. We recommend that State aid be made available for employing county school health coordinators (supervisors of health education).

3. We urge that every effort be made to recruit fully qualified teachers for every field in which they teach, and to transfer as rapidly as possible those assigned to teach in subject fields other than those for which they were especially trained.

RECOMMENDATIONS TO COUNTY COUNCILS (AND TO LOCAL UNITS)

In addition to items listed in the legislative program

1. If your county does not have a county library established by law—work toward that goal! If your county population is small and resources are limited, cooperate with one or more adjoining counties. This year is your last chance to get your establishment grant (Library Services Act fund). (Contact our MCPT library services chairman for help.)

2. Make special plans to encourage all families to secure polio immunization voluntarily and perhaps help prevent a serious outbreak. Remember that 98 million Americans still have not had a single shot of the Salk vaccine! Cooperate with county health departments in sponsoring and operating volunteer clinics, especially for preschool-age children, the school age, and adults. (Contact our health chairman.)

3 Work with the Governor's newly established commission to assist families of migrants employed in Maryland, especially with the programs for prevention

and control of tuberculosis and syphilis, being carried out this summer. Cooperate with the Council of Churches and other groups to establish programs to meet the basic health, education, welfare, and spiritual needs of these underprivileged families and especially of the children.

4. "Unhidden persuaders": Radio, television, movies, comics, pornographic materials, etc. (the "unlicensed teachers"). We feel that what we need is enforcement of existing laws regarding obscenities instead of new legislation; we oppose censorship in principle as an infringement upon our cherished freedoms of speech, choice, and of intellectual curiosity; and feel that parents should teach children by precept and example discrimination and appreciation. (See the PTA guide for evaluation of radio, TV, and comics; the report on pornography; and the monthly TV and movie guide in the National Parent-Teacher magazine.)

5. What services are available in your county or community and are they adequate? Does the PTA membership know about them? For example: recreation facilities, youth organizations, medical and dental clinics and services, school nurses, or nurses aids, library services, how juvenile delinquents are handled, detained, tried, rehabilitated? School accident insurance? Scholarships? Job opportunities?

6. Do you know how many known physically and mentally handicapped or emotionally disturbed children are residing in your county? What is being done for them? Is it sufficient?

7. Check to determine exactly how many high school students dropped out before graduation and why? Is the community concerned about high school party practices, car ownership, marriages, pregnancies, drinking, allowances, optimum use of time in school, homework, reporting system, requirements for graduation, or the like? Is there a "teenage code" of behavior? (Consult our MCPT chairman of high school service and request copies of codes, etc.)

8. Survey your high school's graduates to determine their progress in colleges, their academic weaknesses and assets? The percentage who went into armed services, to junior colleges, to work, further study? The number who did not go for financial reasons?

9. Have you studied your county government; how your schools are financed; composition, policies, and caliber of members of your board of education; proposed and pending legislation; school curricula; how long-range planning for schools involves serious consideration of countywide planning and zoning, etc.? (Are you organized for quick action on any legislation, item, or bill? Do you have a telephone brigade?)

10. What about the safety of your children? Have you determined the existing law, and extent of enforcement, in respect to unleashed dogs? Schoolbus laws? Fire drills? Bicycle regulations? Advise children regarding such hazards as discarded refrigerators, child molesters, swimming holes, guns and firearms, plastic bags, etc.?

11. Check "Looking Into Your School," and the new PTA action program, "Strengthening the Home—Source of our Nation's Greatness" for additional ideas.

For Further Information:

(a) Follow up the dropouts and graduates of your high school by a study of last 3-5 years, and get copies of recent studies made by our State department of education, 301 West Preston Street, Baltimore 1, Md.

(b) Request from Maryland State Teachers' Association reprints from their magazine entitled "How Reading Is Taught in Maryland Schools," "How Spelling Is Taught," etc. (5 East Read Street, Baltimore 2, Md.)

(c) Check projects listed in our own PTA publications: "Looking Into Your Schools" and our new (green) action program. Copies will be sent all PTA's—request others from our State office, 5 East Read Street, Baltimore 2, Md.

Mr. ELLIOTT. Our next witness is Dr. W. B. McCormack, 3 Wordsworth Drive, Hyde Park, Wilmington 8, Del.

May I say to the reporter that the program of legislation adopted by the Maryland Congress of Parents and Teachers, under date of November 5, 1959, will be made a part of the record, without objection, immediately following the testimony of Mrs. Tannhauser.

Following that, the legislative program of the National Congress of Parents and Teachers for 1959-60.

Now, Dr. McCormack, you may proceed with your statement, sir.

STATEMENT OF DR. W. B. McCORMACK, WILMINGTON, DEL.

Dr. McCORMACK. I hope to change the emphasis to another area of special education which in the past has been used mostly in terms of the handicapped or retarded child, but it also applies with equal force to the talented and academically gifted.

It is my understanding that this hearing covers both areas and, accordingly, I shall restrict myself to the question of the talented and gifted group.

In this area, as in others, there are pressing problems at State-local educational levels. These problems need solution because of their importance to our national welfare.

To begin with, there are several conclusions which I would like to present, about which there is fairly general agreement.

1. The intellectual resources of our population are not being adequately developed.

There is a large fraction of children of exceptional ability who are not learning to their capacity. This is due to many factors, the more important being lack of motivation and lack of opportunity.

For any reason, this inadequate development is a serious loss to our national economy.

2. Science education is a critical area of instruction, being necessary both for a liberal education for all citizens, and for the direct use by all these occupations, both skilled and professional, that work with the technical products of our civilization.

The quality of this science education is not adequate in most areas, where it even exists.

These two conclusions sum up the bulk of the problems relating to the education of the academically talented and gifted. Without motivation by social forces, or identification by selection processes of those who are not self-starters, many of these children do not make use of the opportunities that are available.

And most commonly the opportunities available are insufficient to challenge these able children, or provide them with sufficient scope of material.

All too frequently they sink into apathy, produce an average performance, and are lost to our country irrevocably.

This insufficiency in opportunity is most notable in science education. The geometrically swelling output of knowledge of the last 50 to 100 years has not been incorporated into the training of teachers, in the curriculums offered, and especially in the thinking of our people.

Yet these areas relating to science form a new humanities subject, of vital importance to our everyday living, to the jobs of most of us in indirect ways, to our national economy, and even to our national survival.

It is here that the lack of both challenge and opportunity in most of our public schools is most critical for the talented and gifted.

The recommendations I have to make come from my direct observations of the school system in Delaware, and from materials written about other parts of the country. These are six in number, and cover

proposed activities of the Office of Education, and relations with the local or State school system:

1. The Office of Education should undertake curriculum planning and course structure work in the science-math areas in the elementary schools.

This could be much like what they and the National Science Foundation are now doing at the secondary school level.

The child's attitude is fairly firmly fixed by his experiences in early grades. To my knowledge the only national program underway now at the elementary level is basically bibliographic in nature.

There is need for a program that will present fundamental concepts of the physical sciences, such as Newton's laws, number theory, fluid and wave behavior, in interesting and understandable form.

Biology, natural history, and conservation are in good shape where they are used, since the fundamental subject matter has been more stable with time. Even with these upgrading would be desirable.

Beyond subject areas is the problem of teaching students how to use their minds most effectively, for creativity, logic, self-evaluation, abstraction, and other aspects of mental discipline.

2. A basic problem is retraining of elementary teaching staff. Many of these have no liking for or understanding of physical science, especially for fundamental concepts.

At the secondary school level this problem is being handled by the summer seminars run by the National Science Foundation. Such special training is now federally encouraged or subsidized for teachers of the handicapped and retarded.

We need to extend this into the elementary teacher level as a standard program.

3. The identification of the gifted and talented, beyond those who happen to identify themselves by good marks in a good school, is far from being under control.

Yet there are perhaps half of the academically able who never appear on the surface to have ability. These should be found in the elementary grades. A commonly suggested auxiliary is a national achievement test program, or national adoption of one of the test programs already in existence. There are four national ones used in this field.

4. Once the gifted and talented child has been found a program to fit his learning ability must be available.

In many schools the supervisory attention or staff interest in this problem has been sadly lacking. They are busy enough with their class problems.

The methods spoken of are classroom enrichment in heterogeneous groups, partial homogeneous grouping in selected subject areas, and multiple-track programs with relatively homogeneous groups. This should mean smaller classes for the gifted and talented, of 12 to 20 students, rather than the 25 to 40 usual class size.

For a school to work out special programs normally means the development of additional program material and provision of special supervision. There needs to be an encouragement to do this, beyond simply having a worked-out program available at the Office of Education, or elsewhere.

One possibility is a matching fund proposition, much as is done for vocational education, for the additional costs.

5. A more severe problem, and one having the greatest financial cost, is that of supplying the extra teachers for the smaller classes.

Many school districts right now are aiming at overall larger classes as a means of saving money with our increasing pupil loads. There are pressures in my own State Legislature in Delaware aimed in this direction. No more shortsighted policy, with disastrous potential effects in student intellectual development and motivation, could be imagined.

One possible counter to this trend, to encourage smaller classes for the gifted and talented, would be a Federal subsidy. Although this is another case of what should be an unnecessary approach to the Federal Treasury, I see no other immediate solution to this financing problem.

The change of opinion by unenlightened school board members and local elected officials, is a slow, almost infinitesimal process, and will not give quick results.

With suitable, intellectual standards set up for subsidy qualifications, such a class of 15 pupils could draw perhaps \$2,000 to subsidize a teacher.

With perhaps some 100,000 such classes potentially formable in the country, this is a \$200 million price tag. An equivalent approach is now used to educate the handicapped and retarded, by special classes of reduced size, and extra money allotments.

To my mind, the academically talented and gifted are certainly of equal importance.

6. Related to this class size question is another serious problem of scattered schools, especially in rural, small town, or some suburban areas.

It is often impossible to find more than a few able students in a given school district. This problem may be soluble only by a subsidized bus transportation program for these pupils, for at least 1 or 2 days a week. By such transportation enough could be gathered together to justify a special class program.

The resource of the talented and academically gifted is one of the most precious we have as a nation. It should not be wasted by relying on our present laissez-faire methods.

I feel that Federal action in this area would have a marked stimulatory effect on our whole educational system.

Mr. ELLIOTT. Thank you, Doctor, very much.

Our next witness is Mr. Phillip Walsh, of the National Recreation Association. Mr. Walsh.

STATEMENT OF PHILLIP WALSH, NATIONAL RECREATION ASSOCIATION

Mr. WALSH. Thank you.

I am here as a representative of the National Recreation Association, more specifically, of its consulting service on the aged, ill, and handicapped.

The National Recreation Association is a nonprofit organization which provides direct service, consultation, research, and demonstra-

tion in all areas of recreation. Our section is devoted to recreation as a therapy, a part of the total rehabilitation process.

We are interested in this bill because recreation therapy is often an important part of rehabilitation and because we are convinced of the great need in our field for the help this bill can provide.

I want to tell you about the role we play in rehabilitation and what are some of the needs in our field.

Recreation therapy is, simply, the use of any recreational activity to aid in the recovery of a patient. It is recognized by the American Medical Association, the American Psychiatric Association, and the American Hospital Association, as being an integral part of the total rehabilitation program.

The importance of recreation therapy has been greatly emphasized by Drs. Howard Rusk and Carl Menninger.

States are beginning to provide for it through legislation; California and New York have made recreation mandatory for their nursing homes and homes for the aged.

New Jersey, Maryland, Delaware, and Pennsylvania, are currently considering the engagement of recreation consultants to aid in this area.

The Department of Health, Education, and Welfare has shown interest in this work and is presently supporting two studies for us.

To illustrate the role of recreation therapy, some examples may be drawn from the work we have been doing in this State, in Sussex County. This is a study by the National Recreation Association, with the help of the Sloan Foundation, to see if the needs of rural areas can be met through the use of volunteers, in a coordinated program.

We have been working in three types of institutions, a general hospital, a welfare home, and several nursing homes.

One of our patients in the hospital had been doing very active, outdoor work when an injury caused a paralysis. His work was important. It had involved a great deal of training and study. Paralysis made it no longer possible for him. He was depressed, bitter; he was certainly not receptive to vocational training.

At his doctor's request, recreation therapy is largely prescribed; we started involving him in simple, passive activities—movies, entertainments, and the like.

He began to respond. A volunteer then introduced him to painting and, to his surprise as well as that of the volunteer teaching him, he showed a rather remarkable talent. He painted several pictures and then made frames for them as Christmas presents.

Through this, he gained some confidence in himself. Instead of withdrawing further and further from contact with others, he was drawn into contact and is now ready to learn to be self-supporting through vocational rehabilitation.

Here the first step was a recreation activity.

Another patient, at one of the nursing homes, was afflicted by arthritis of her hand. For the most part she didn't exercise it. We started her working with clay and, after gaining greater use of the hand through this, simple loomwork was introduced. These activities provided the necessary exercise in which she had formerly been uninterested.

At the welfare home, there were patients whom the director thought perhaps incapable of participation in any activity. For the most part, they refused to move. It took time, but given a recreation program they began to use wheelchairs, walkers, and even their own power to attend the bingo sessions, parties, and other group activities.

So often in institutions it seems that the patients' families have put them in, and they sit there, waiting for God to take them out.

Here recreation can bring them a reason to live their life even if they cannot make a living.

These examples are the kind of thing that recreation does. Now as to the present position in our field:

Here in New Jersey, the situation is fairly typical of the rest of the country. In the hospitals, the veterans hospitals have good recreational programs. The mental hospitals have programs, but not enough money to run them well. The other hospitals, with the exception of two, have no recreation programs.

In the nursing homes, the situation in the nursing homes has, within the last 6 months, become much better than in other States due, largely, to our demonstration projects. Of 125 nursing homes, 31 have instituted full- or part-time recreation programs.

In the homes, homebound patients are uncounted, their needs are not known, and there are no facilities for recreation services to them.

In our Sussex County project, we're about at the end of this study. We know we've convinced the owners and administrators of the institutions involved of the value of this kind of program. We've tried to find a way, through a volunteer council, in which it can be financed. Whether or not this will be the answer here, or in similar areas, we don't know yet.

We do know that many answers need to be found for all of the country.

Senator McNamara has conducted an investigation into the institutionalized and stated, and I quote him:

A storage bin philosophy under which patients who could be restored to active life are condemned to needless invalidism still prevails in spirit or in fact, in most nursing homes. The needs of the patients are not met, for instance, there is a total lack of recreation activities.

There are 25,000 nursing homes and homes for the aged in the United States. The Department of Health, Education, and Welfare, made a study of these in 1955, and there was so little evidence of any type of activities for their patients that the Department could not come up with any pertinent statistic whatsoever.

Provision is generally made in nursing homes for adequate nursing, dietary care, and absolute fire protection; but less than 1 percent of the 25,000 homes gave their patients more than bed and bored—b-o-r-e-d.

The hospital situation is better. A National Recreation Association study of recreation in hospitals, shows that of our 7,000 hospitals, 2,000 have departments of recreation therapy, and since there are, the larger hospitals—city and VA—which can afford them, they service 62 percent of the total number of beds, more than half, a much better situation than that of the nursing homes. But still, there are a lot of people in the remaining unserved hospitals.

In the home, I cannot give you any figures on the homebound. I don't know if anyone can. We do know that there are thousands of severely disabled people who are not in institutions.

Some Government attention has been directed to those homebound who are ready to receive vocational training and placement, and very recent consideration has been given to recreation activities—you might want to call it social rehabilitation—to bring about this readiness. However, very little is known of the extent and needs of these homebound.

Our office is currently working for the Office of Vocational Rehabilitation in two areas related to them.

One, studying the need for recreation consultation concerning patients in sheltered workshops and demonstrating methods to meet this need.

The other study, a study to determine the psychosocial needs of a large group of homebound and a demonstration to both show and document how these needs can best be met.

As another investigation into the homebound situation, we are planning a pilot project in Sussex County—a similar one to the one we have been doing there for the institutionalized.

In general, though, the recreational needs of the homebound have hardly been touched.

In any of the studies I have mentioned, another great lack has been evident. It is that of qualified personnel, and while we find far too little being done with recreation in nursing homes, in hospitals, and for the homebound, we also find that in the hospitals which do try to provide it, there are, today, over 2,000 well paid positions for recreation therapists going unfilled because of the lack of trained workers to fill them.

Even in our office at the National Recreation Association, whenever a study or project is approached, the first question to be answered is: Who can we get to do it?

Funds available for recruitment and for scholarships in our field: Actual studies as to the most effective ways of using recreation therapists in the processes of total rehabilitation are needed.

We need to get to the homebound, to find out what they need, to provide activity centers and other services for them.

These are some of the areas in which the Federal Government can and should help.

We are rather proud of what our section of the National Recreation Association has been able to do to further rehabilitation, but we are constantly made aware of the tremendous amount of work to be done and have always recognized that we cannot hope to do it all unaided.

The Vocational Rehabilitation Act is the kind of legislation we feel is needed.

Thank you.

Mr. ELLIOTT. Thank you very much, Mr. Walsh.

The next witness is Miss Elizabeth Titsworth, assistant superintendent of the New Jersey School for the Deaf at West Trenton, N.J.

Miss Titsworth testified earlier today, as a representative of the workshop from the hearing handicapped group or section of that workshop, and when you have finished we will have heard 35 witnesses today, one following the other.

May I also, before Miss Titsworth begins her testimony, say that the committee cannot but be impressed by the fine coverage that the U.S. press and Hudson Dispatch have shown us as their representative, Mr. Calter and Miss Schnieder have listened to the same 35 witnesses that we have.

You may proceed, Miss Titsworth.

STATEMENT OF ELIZABETH TITSWORTH, ASSISTANT SUPERINTENDENT, NEW JERSEY SCHOOL FOR THE DEAF, WEST TRENTON, N.J.

Miss TITSWORTH. Mr. Elliott, may I just give the highlights, with the details to be included in the report that I handed in?

Mr. ELLIOTT. Yes, ma'am.

Miss TITSWORTH. Inasmuch as our students do come from all the counties in the State, I felt it was necessary to treat that separately.

There is a serious shortage of teachers. In 1950 our staff was made up entirely of trained teachers. This past year our staff is made up of 50 percent trained teachers.

Mr. ELLIOTT. How many students at the New Jersey School for the Deaf?

Miss TITSWORTH. 360 students.

Mr. ELLIOTT. The training of your staff of teachers has, from the standpoint of the degree of attainments, at least in the professional training, has deteriorated 50 percent in 10 years?

Miss TITSWORTH. Yes. The conditions behind this are that in 1950 we had predominantly an older staff and upon retirement we have not been able to replace with trained teachers and our enrollment has increased and once again we have not been able to hire trained teachers in the new positions that have been opened up.

In regard to increased enrollment our present enrollment is 360. We will graduate 16 this year and our waiting list is 51, which indicates an increased enrollment of 10 percent next year, which is quite in the pattern of the past 2 years.

Mr. ELLIOTT. How much has your enrollment increased in the last 10 years?

Miss TITSWORTH. I am sorry; I don't have the enrollment at that date, Mr. Elliott.

In regard to the shortage of clinic facilities, we feel that very badly, but realize that inasmuch as New Jersey has no medical school affiliated with the university, and that is the usual development for such clinics, we are at a disadvantage and feel that if one could be made available in the State it would be of great help to the students and to the hard of hearing who are not in classes for the deaf, too.

We would recommend that the granting of scholarships to qualified people who wish to train as teachers of the deaf, the expanding of present training centers. We have set up an emergency training center with Trenton State College and since 1956, 49 have been enrolled.

At present 23 of these persons are on our staff, 8 of them in the first year of training, 8 in the second year of training, and 7 have completed training.

There has been a dropout of 10 which is 20 percent.

If the teachers could be relieved of the responsibility of carrying a classload during the year of study I feel sure we would not have the dropout that is found in this breakdown.

In conclusion I would like to say the conditions for the future look worse than better for we are not adding new personnel, but just training those that are in the field already and deaf children into independent constructive persons who fit into society and are good citizens.

Many deaf children are being denied the help that they need. Financial help would definitely improve this condition. Thank you.

Mr. ELLIOTT. Thank you very much, Miss Titsworth.

(The formal statement of Miss Titsworth follows:)

FORMAL STATEMENT OF ELIZABETH F. TITSWORTH, ASSISTANT SUPERINTENDENT,
NEW JERSEY SCHOOL FOR THE DEAF

Existing problems that developed during the war years and the years that have followed:

- I. Serious shortage of trained teachers and allied personnel.
- II. Increase enrollment.
- III. Increase in number of deaf children multiply handicapped.
- IV. Shortage of clinic facilities.
- V. No educational research.

Conditions related to above problems:

I. Teacher and personnel shortage

A. Academic instructors—New Jersey School for the Deaf:

	Total num- ber	Trained	Untrained
1950-51.....	33	33	0
1951-52.....	33	27	6
1952-53.....	33	25	8
1953-54.....	31	23	8
1954-55.....	31	21	10
1955-56.....	35	23	12
1956-57.....	37	23	16
1957-58.....	36	19	17
1958-59.....	40	19	21

NOTE.—Over 50 percent of staff untrained in 1959.

B. Conditions behind 1950's 50-percent untrained staff:

1. 1950 staff predominately an older staff and no trained replacements available for teachers who retired.
2. Increased enrollment necessitated increasing size of staff. No trained teachers available.
3. Circumstances that discourage 1 year of graduate study:
 - (a) Satisfactory employment available in other fields without further study.
 - (b) Tuition costs are between \$1,000 and \$2,000, depending upon the college or university.
4. Teacher salary scale is the same as public school and lower than salaries of high-paying communities in northern area of the State.
5. People generally locate in work within a 30-mile area of their home.
- C. Additional staff needed for teacher-training program and supervision.

II. Increased enrollment

A. More deaf children:

1959-60 data:

Present enrollment.....	360
Graduates, June 1960.....	16
Present waiting list.....	51

Ten-percent increase in enrollment, September 1960.

B. Lowering of entrance age to age 4.

III. Increased incidence of multiple-handicapped deaf

A. Cerebral-palsy, deaf children with language disorders, crippled and mentally retarded are included in present enrollment. These children must be placed in classes of six and seven.

B. Research programs do not exist regarding the best methods of teaching multiple handicapped.

IV. Shortage of clinic facilities

New Jersey's lack of medical schools affiliated with universities has left the State without the normal situation under which such clinics develop.

V. No educational research

A. Shortage of staff.

B. Lack of clinic facilities.

SUGGESTED PROGRAM CORRECTING PROBLEMS

I. Granting scholarships to qualified persons who wish to train as teachers of the deaf

II. Expand present training centers

A. Status of in-service training program—New Jersey School for the Deaf:

1. Established in 1956, two-year program; 49 enrolled between 1956 and 1959. Breakdown of above 49:

On teaching staff-----	23
In 1st year of training-----	8
In 2d year of training-----	8
Completed training-----	7
Enrolled as a refresher course-----	9
Teaching elsewhere-----	7
Did not complete training-----	10
Total-----	49

2. This program needs expanding, stabilizing, and financial support:

(1) At present no new teachers are being prepared for future demand. All enrolled are on the teaching staff.

(2) Present program dependent on two members of Lexington School for the Deaf as instructors, three members of own staff and volunteer services.

(3) Salaries paid instructors are lower than salaries paid for same services at other training centers.

(4) Require 18 of our teachers to be on campus from 8:30 a.m. to 6 p.m., 2 days per week.

B. Majority of existing training centers are equipped to take increased enrollment.

CONCLUSION

Conditions for the future look worse rather than better.

We are not adding new personnel to the field.

Deaf children develop into independent constructive persons who fit into society and are good citizens. Many deaf children are being denied the help they need. Financial help would definitely improve this condition.

Thank you for the opportunity to present these problems.

Mr. ELLIOTT. Now, I call the Reverend John P. Hourihan, of the Apostolate for the Deaf, Newark, N.J.

Did I pronounce your name correctly, Dr. Hourihan?

I am happy to have you and happy that we can accommodate your desire to be heard here now.

I will be very regretful when 10 minutes from now I give you the signal.

STATEMENT OF FATHER JOHN P. HOURIHAN, APOSTOLATE FOR
THE DEAF, NEWARK, N.J.

Father HOURIHAN. I hope I can get my Ph. D. as easily as you just called me.

The problems of children and adults who are deaf or hard of hearing are unappreciated, if not greatly misunderstood by the general public. There are several reasons for this.

First, there is a hidden handicap. Because these children do not appear physically handicapped their cause does not have the dramatic impact upon the public as do some of the others.

Secondly, the parents of these children are not as strongly organized nor have they learned how to capitalize on public relation methods as have some other parent groups.

This may be due to the fact that during the early years of their child's life they nourished the hope that he will be as normal as other children and do not feel the need to band together with other parents of handicapped children.

Three, in adults it is a social handicap with which there is associated a certain stigma which makes them want to withdraw from social intercourse and often induces psychological problems.

Such people are not inclined to organize or lobby as are adults suffering from physical handicaps that evoke more sympathy from society.

It appears, however, that the situation is gradually changing due to the dedicated efforts of politicians, educators, and rehabilitation workers.

More influence than any other will be the role of this committee who, by giving so much of your time and effort to the consideration of the unmet needs in the area of education and rehabilitation of the deaf and hard of hearing will focus the spotlight of Government interest on this problem and thereby impress the public with the idea that a hearing loss is a community loss and deserving of as much attention as any other more dramatic handicap.

Therefore, I consider it an honor to appear before this committee, a privilege to be of assistance to you in your work.

Having worked with the deaf at Gallaudet College in Washington, D.C., having been in association with members of the Department of Health, Education, and Welfare, being a trainee, teacher in training at the Lexington School for the Deaf in New York City and directing speech and hearing programs in the diocese of Newark, I feel in a small way qualified to give testimony.

In regard to the Framton study group, we wish to state that we wholeheartedly endorse their studies and are working with them.

In regard to Mr. Elliott's bill, H.R. 494, we wish to state that we heartily approve the idea that Federal grants in aid for scholarship be given to students who wish to become teachers of the deaf, speech therapists, audiologists, to relieve a critical situation which exists in the area of education of the deaf and hard of hearing.

In regard to my own personal opinion as to what are the unmet needs in this area we wish to inform you there are many. These unmet needs cut across the total area of our population, preschool, school age, adults, and senior citizens who suffer hearing losses that come with old age.

In all these groups with whom I have come in contact in New Jersey, I have found unmet needs that I am sure will interest your committee.

In general these needs may be summarized as men, money, and facilities.

In particular, there is need to educate the public about the necessity for early diagnosis so that children who are acoustically handicapped can be placed in proper programs.

Among educators it is felt that if these children can be placed in a special nursery or preschool program they will then receive help that will give them the foundation for future educational programs.

There is also a need for more such special preschool programs. Related to this is the need to establish parent guidance programs in order to educate the parents of the various aspects of the handicapped, himself, so that they can develop proper emotional attitudes toward the child and his handicap.

Such programs should begin early in the life of the child so that during the very impressionable period of his life he will receive the necessary emotional support from his parents.

Also, there is a need for more speech and hearing clinics to work with the medical profession for these children when they are discovered.

With regard to the school age children, there is an urgent need for more trained teachers of the deaf and hard of hearing to work with the children in special classes and special schools, whether public, private, or parochial.

I have a personal as well as a professional interest in such teachers because during the past 8 years I have been working with 150 students from teacher training programs. In those years I was able to encourage only four to enter training programs on a graduate level.

However, if there had been scholarships to defray the cost of such programs, I believe there would have been 10 times that number.

The establishment of new teacher training programs as well as the expansion of existing programs at the university level is a need related to this area, too. Such action would then increase the number of qualified personnel at the university level which would also turn its attention to carrying on much needed research programs.

For the adults there is need for more social workers and psychologists and orientation in the problems of the deaf.

In November the Office of Vocational Rehabilitation conducted a workshop on the psychological assessment of the deaf, and here the psychologists admitted this is a relatively unexplored area.

If the Office of Vocational Rehabilitation were given an increased budget on a Federal and State level we could take on other similar projects.

For our senior deaf citizens, there is need for expanded social, recreational, and cultural programs conducted by a staff competent to deal with the deaf.

It also would be beneficial to explore the need for homes for the aged deaf.

In conclusion I wish to state that I deliberately avoided burdening you with statistics because I know that others have massed very impressive figures. I come before you as a representative of the deaf and to speak in their name.

Thank you and may God bless you in your herculean undertaking. Mr. ELLIOTT. Thank you very much, Father Hourihan. Our next witness is Mr. E. B. Whitten, who must get away by 5 o'clock.

Mr. Whitten is the executive director of the National Rehabilitation Association, headquartered at Washington, D.C.

We who have known Mr. Whitten through these years recognize him as being a very outstanding and devoted scholar and worker in this field.

May I say to you, Mr. Whitten, that we are very happy to have you.

It is up to you now to make that plane.

STATEMENT OF E. B. WHITTEN, EXECUTIVE DIRECTOR, NATIONAL REHABILITATION ASSOCIATION, WASHINGTON, D.C.

Mr. WHITTEN. Mr. Chairman, you won't have to caution me at all.

Let me say, first Mr. Chairman, and I, too, like Mr. Page, was seeking some dramatic way to attract the attention of the public to rehabilitation. He seemed to challenge this committee to find such a method.

Since it is not likely that Mr. Flemming will be able to repeat the cranberry episode, I suggest that we ask him to prepare a training manual during the next few months which might get the desired results that we want.

As you people know, the National Rehabilitation Association is the original sponsor of H.R. 3465, which is one of the bills upon which you have been asking and receiving a great deal of testimony.

Since this has become one of the chief topics of conversation at the workshops and hearings, I thought probably it was about time that we showed up at one of these regional workshops to say a few words about just how we came to propose this type of legislation, which is becoming so popular and behind which now I think you might say almost the concerted rehabilitation movement is standing.

Incidentally, when you have your roundup hearings in Washington, we shall ask your permission to appear before the committee to give very detailed testimony on the bill, itself, and the details of it which will be necessary, of course, in the technical sense, but today we want to talk really about why we came to choose this approach toward meeting certain needs of the handicapped.

We think these needs and particularly with reference to the adult program which I am going to talk about first can be summarized in two or three different areas.

In the first place, evaluation of rehabilitation potential is absolutely essential to a good job in rehabilitation. We feel that probably the weakest aspect of the State-Federal program of rehabilitation now and probably this is likewise true of almost all children's programs, is that there is an inadequate evaluation of rehabilitation potential at the beginning.

This is frequently an expensive and time-consuming process and the agencies at the present time are not geared by practice, philosophy, or by legal authority, to carry on the type of evaluation work that

is needed if we are to know, as we begin serving an individual, what his potentialities are.

Now, the second need that we have found is that one which has been emphasized here many times today.

We know that there are hundreds of thousands, even millions of people in this country, who are being denied the benefits of rehabilitation because they are being adjudged to be not feasible for vocational rehabilitation.

This is not just a matter now of talking and wild gestures. The old age and survivor's insurance cash benefits program alone has identified more than 800,000 individuals who are said to be not eligible for benefits because they are capable of some substantial gainful employment, it is thought, but who are found to be not feasible for vocational rehabilitation under existing laws.

Now, these are people for whom the names and addresses are available.

So this is not something out of the air. This is only one of the evidences of this tremendous need.

Now, the third need is for a well-rounded program of rehabilitation facilities. Under the Hill-Burton Act it is possible now to build a limited number of what are called comprehensive rehabilitation centers, so called because they must have medical, psychological, social, and vocational aspects.

It is not possible under existing legislation to build workshops such as have been described here today, or many of the specialized rehabilitation facilities that are absolutely necessary if the job is to be done which many people have indicated today ought to be done.

Therefore, in H.R. 3465, which is frequently called the independent living rehabilitation bill, we have provided really a complete program. No one title will stand by itself.

Independent living bill is one title, but the facilities bill and the evaluation titles are equally important and are badly needed if the objectives of the first are to be attained.

Therefore, although naturally one group may be more interested in facilities than they are in independent living, another group more in independent living than they are in facilities, and while some may emphasize evaluation services more than others, actually we think you ought to consider this measure in the broader aspect as meeting the total need.

It is not that we could not make progress to some degree with less than a total bill, but it is all needed in some well-rounded program. That is why we came up with this after several years of intensive study of needs in this country.

Now, a few words about training. We as much as any other organization recognize the need of trained personnel. We have really a good start being made in the Office of Vocational Rehabilitation now under the 1954 legislation.

However, examination should be made of the wording of that authority to be sure whether it is broad enough to enable the Office of Vocational Rehabilitation to do a complete and adequate training job in the area for which they have responsibility.

There are some, for instance, who think this does not.

Now, we are supporting this bill, H.R. 494, to train teachers for the deaf and speech and hearing pathologies, and audiologies, but in doing so we want to say this is not the preferred way we would like to see this job done.

Although we recognize the need of advancing upon the categorical fronts and we have frequently come out and supported categorical legislation, we believe that the soundest basis would be to establish in the Office of Education a training program with broad authority to deal in all the areas of disability whether they are named or not—maybe you would want to name certain areas there—and to let the Office of Education try to advance the training needs for rehabilitation personnel in the schools on as near as possible a common and unified front as the Office of Educational Rehabilitation is now attempting to do in the area of adult rehabilitation.

That, to me, in our association, representing, as we do, rehabilitation people in all the programs and not concerned with any one category of the disabled, but all of them, we feel that probably will be the soundest approach to make.

Mr. Chairman, there are a great many things I could say about this legislation as you know. In fact, when I get started I find it difficult to start even for the 10-minute limitation, and a plane I am about to catch, but I believe I will pause at this time. I don't think I have taken up quite all my time, so if there is a question that someone wants to ask, I will try to answer it.

Mr. ELLIOTT. We have been studying H.R. 3465 here for about a year. Do you have recommendations on draftsmanship with respect to the language of that bill?

If so, I would like to have you submit them within the next 60 days.

Mr. WHITTEN. Mr. Chairman, we have already been thinking along that line. We, ourselves, have found, I am sure, 15 or 20 places in the bill where we think language can be clarified and we have such prepared and ready to submit to the committee.

You see, we have always taken the position about this legislation that our responsibility was to direct the attention of the American people and the Congress to this great need. We have never taken the position that any one bill with any particular language was the only way to do this job. As this bill has been discussed over the country, privately and in groups like this, many fine suggestions have been received that we think will improve the legislation.

Mr. ELLIOTT. Do you know of any other bill of this nature that has had more thorough discussion than this one is undergoing?

Mr. WHITTEN. No, sir; I do not. In fact, when you started these hearings, I don't mind saying I was a little bit concerned. I was afraid it was going to be a delaying process in getting something done.

Now I feel very keenly that this kind of process was necessary and there is a much better understanding of this bill and its objectives in the country now than there possibly could have been if we had not had this fine series of hearings and workshops which your committee is conducting. So we are very happy about the whole thing, but we don't want any more delay than is absolutely necessary.

Mr. ELLIOTT. We were very successful, as you know, in conducting nationwide hearings on the school needs before we passed the National

Defense Education Act. I cannot help but feel—I do feel very strongly—that a piece of legislation to be understood has to be dramatized in the precincts where people live.

I think if we were supermen and could hold these hearings all over the country and if the people all over the country could understand what the needs are, we could pass this bill, or a better bill.

Mr. WHITTEN. The growing understanding of the people, as evidenced in these hearings, has been remarkable. There has been a better understanding of it now than I realized there was.

It is quite revealing to me to read what happens in other workshops and come here today and see organization after organization with which we have had no direct contact at all who have taken the opportunity to study this legislation and evaluate it in terms of their own local situations and have come up with the idea that this would be a big advance to help them with their programs.

In other words, I think the rehabilitation movement is more unified today than I have seen it in the 12 years I have been on this job, unified in favor of a program which almost everyone can agree will help, although they may not agree exactly on details of how it ought to be done.

Mr. ELLIOTT. Thank you very much, Mr. Whitten.

Mr. QUIE. Mr. Whitten, you gave a wonderful presentation and I am greatly impressed by it.

It just occurs to me that there is one area that you have not brought out that undoubtedly you have done a lot of studying on, and that is the prevention of people becoming handicapped. Do you think that this is an avenue that should be studied, and do you think that we are doing an adequate job of seeing that the people don't become handicapped?

Mr. WHITTEN. No, we are not. We have seriously considered in our organization whether we ought to present or, at least, call the attention of this committee to some of the particular needs at the time this bill is considered in the roundup hearings.

For instance, we think there must be a timelag of at least 5 years between the time when, for instance, we find out how a problem ought to be attacked medically with respect to some disability and the time that the hospitals and other institutions of the country actually adopt this practice.

For instance, I am told that if I had a stroke, apoplexy, I believe they call it, if I had a stroke, which is more likely to happen to me than any other disability at my age, that in the Washington area there are probably only two hospitals where the most modern methods of treating strokes will be found at this time, which almost makes a person wonder whether he ought not to carry a tag around his neck saying in case I have a stroke please send me to a certain hospital or to a certain physician.

I think there is a tremendous need there in getting into our chronic illness hospitals and our general hospitals and trying to put on demonstration projects that will help to bring about more quickly the application of the knowledge which we possess now in considerable degree.

I also think there are great weaknesses in children's programs that need to be corrected.

You will notice there is one paragraph in my statement about that. I don't think that crippled service in this country has developed nearly so rapidly as the vocational rehabilitation program has.

That ordinarily is not in the purview of your committee, being handled by the other committees of the House and Senate, but I really feel it is an obligation of this committee to make some study of this, too, and to present to this committee some of your findings.

I think we could vastly strengthen our crippled children's services in this country. That is fundamental to any good and complete program of rehabilitation. That is the kind of prevention I think you have in mind.

There is a real need there. We are certainly anxious to cooperate in finding ways to meet it.

MR. QUIE. I think you are in a position to give great leadership in that.

MR. WHITTEN. We have been having conferences with people in the American Public Health Association, American Public Welfare Association, and in the proper bureaus of the Government, along this line.

It has been more difficult, however, for people in some branches of Government to come out with specific findings that they can agree upon in that field than it has for us in rehabilitation.

I think a much more cohesive working together may be more effective than in some other areas, but there is a great need and you can make a great contribution by exploring it.

MR. ELLIOTT. Thank you very much, Mr. Whitten.

Before we get back to the workshop reports, I have one other witness who must get away. That is Mr. Albert Venutolo, president of the Jersey City Hearing Society of Jersey City.

After Mr. Venutolo testifies, we will return then to the workshop reports.

Mr. Venutolo, you may proceed.

STATEMENT OF ALBERT VENUTOLO, PRESIDENT, JERSEY CITY HEARING SOCIETY, AFFILIATE OF AMERICAN HEARING SOCIETY, JERSEY CITY, N.J.

MR. VENUTOLO. At this time, Mr. Chairman, may I offer my written statement for the official record.

MR. ELLIOTT. The written statement of Mr. Venutolo will be made a part of the record after his oral presentation, without objection.

MR. VENUTOLO. My name is Albert Venutolo, president of the Jersey City Hearing Society.

At this time, Mr. Elliott and your colleagues, in behalf of the Jersey City Hearing Society, we wish to thank you for affording us the opportunity to appear before this hard working committee.

MR. ELLIOTT. I am sure the gentleman knows that it would be our desire to hear everybody at greater length, but we have about 30 witnesses today and about 30 tomorrow.

MR. VENUTOLO. Believe me, Mr. Elliott, I am going to make it short.

Mr. ELLIOTT. No, I am not saying that. You have your time. But what I am saying to you is that I wish it were possible for us to do a more thorough job.

Mr. VENUTOLO. I feel personally that the American Hearing Society and the American Speech & Hearing Association has presented testimony adequately enough whereby your committee has been given a general picture of the problem of the deaf and hard of hearing.

I would like to confine myself to the testimony, the geographical location of Hudson County pertaining to the problems of the deaf and the hard of hearing.

Hudson County with a population of 700,000 people, with an incidence of roughly 5 to 6 percent, we have about 45,000 people that are deaf and hard of hearing. That includes all ages.

Mr. ELLIOTT. You have how many?

Mr. VENUTOLO. About 45,000 of all ages, Mr. Elliott.

Mr. ELLIOTT. That would be 1 in 15, would it not?

Mr. VENUTOLO. Roughly.

The Jersey City Hearing Society has been in existence since 1920 and we have always devoted efforts toward helping the deaf and the hard of hearing.

To date, based on the opinion of experts, a community with 50,000 or more, they claim you should have at least 1 speech and hearing clinic with 1 qualified audiologist and 1 speech pathologist.

Mr. ELLIOTT. To each 50,000 people?

Mr. VENUTOLO. That is right.

To this date, Hudson County has none, has no speech and hearing clinic whereby individuals, regardless of age, that have the impairment of hearing or are totally deaf, where they can be completely diagnosed and evaluated.

Of course, the Hearing Society has been working feverishly toward this end. In fact, in my testimony I have a formal presentment of a possible establishment of a hearing clinic, the Jersey City Hearing Center, as far as back in 1958.

To shorten my testimony I will proceed along the age group under the general heading of special education.

In considering the preschool child of Hudson County, we have roughly 50,000 taken at a 0.5 percent incidence, which would give about 250.

This, I say, is ultraconservative.

Mr. ELLIOTT. What does that mean?

Mr. VENUTOLO. 250 children of preschool age. In other words, you have 50,000 preschool children in the country. Then we take a 0.5 incidence, which is a conservative incidence, which will give us approximately 250 children.

Mr. ELLIOTT. Would that be deaf, or both?

Mr. VENUTOLO. Deaf and hard of hearing. I am making my incidences very conservative because I want to impress upon you, gentlemen, that even with a slight incidence you can see the need for help in this particular handicap field.

For example, in Denver, Colo., they just conducted a hearing test on a population of 400,000 in Denver, 4,000 preschool children. They found that 5 percent of 4,000 children had a significant hearing impairment.

To go on further, in Jersey City we have 30,000 children. Taking the incidence of 0.5 percent, you wind up with 138.

This all leads to one thing: As far as I am concerned, in working with the deaf and hard of hearing, all ages, I feel that the preschool child has really been neglected; I mean to a point where parents have to take their children out of the county, out of the city, maybe two or three times a week, to get proper therapy or proper evaluation so that when they do get to school the case history is available for the local board of education, and to this date we have no such service in Hudson County.

As you know, from previous testimony, an early evaluation by a qualified audiologist or qualified personnel in a speech and hearing clinic with a preschool child, would be of utmost importance, because the opinion of experts is that the sooner you get that child sensitive to sound and get him speech therapy or speech reading, whatever is necessary, the easier it is going to be for the local board of education.

At this stage of the game it is very important that the parents are also guided properly, because sometimes, in fact, I have experienced this, that parents become more of a problem than the child insofar as they are not taught to accept certain setbacks.

In other words, we cannot explain to them that time is of the essence, you will see results; we know that results will come about if you have patience.

Now, I would like to proceed now to the school age child. The public schools of Hudson County are broken down, the public school personnel of school age, we have 70,000; parochial schools, we have 30,000.

Based upon a 0.7 percent incidence on 100,000 pupils, we have 756.

Now, I best exemplify our problem by just citing one important fact. We have one class in the county, one class in the county, that has nine children that have a severe loss of hearing, a significant loss of hearing, where the age span is anywhere from 5 to 12 years, representing four different grade levels under one teacher.

This is a physical impossibility. The children cannot receive the proper type of instruction, and all I can say here is God bless the teachers that work with them.

It really is a problem, and I think that in this part I would like to say we really need teachers. The critical shortage is here, and it is definite.

I would like to go on now to my conclusion on the special education phase.

What is needed to help evaluate the unmet needs of the special education in the field of deaf and hard of hearing? Of course, my society officially goes on record as backing up the House Joint Resolution 494 to include Federal grants for the following.

I have heard a lot of testimony today, but I did not hear a survey that would start from birth. In other words, we get competent legislators, educators, clergymen together and try to get a coordinated effort where we can get information.

In other words, the big problem, Congressman, is that a lot of the children are not found until they are 3 or 4 years old.

Then we will go to the second phase of my conclusion, research.

High institutions of learning should deal with better methods for teaching, including vocation which is very important.

In other words, it is not that we want the best in the teaching field that are able to learn and grasp and teach; we have to make sure that they are adapted, that they want and that they will love their work.

Of course, workshop research is very important, and field study.

No. 3, we need teachers. Based on research findings, offer courses to the present and future teachers, based on research, public relations, and education in the community are named to pay the handicapped teachers more money.

Right now, as I understand, we need 500 and we have about 120.

Now, may I just sum up rehabilitation. I feel I don't have enough time here, but based on a 4 to 5 incidence in deaf and hard of hearing, Hudson County has about 45,000.

There is only one out of six cases—that is taken from the Rehabilitation Commission of New Jersey—there is one out of every six that is getting rehabilitated.

Public Health states that 8,000 become disabled every year and I would say this personally. If the Government becomes realistic, let us be business minded about this.

It is a known fact that every dollar that is thrown into rehabilitation, the Government will realize \$10 in taxes.

That I received from the Rehabilitation Commission of New Jersey report.

That concludes my statement.

Mr. ELLIOTT. Thank you very much, Mr. Venutolo.

I have two statements which have been submitted for the record. The first is a statement by Julian G. Stone, president of the New Jersey Rehabilitation Association and the second, a statement by Dr. Boyd E. Nelson, director of special education, New Jersey State Department of Education.

Without objection the statement of Mr. Venutolo, together with the Statement of Mr. Stone and Dr. Nelson, will be placed in the record at this point.

(The statements referred to follow:)

REPORT BY THE JERSEY CITY HEARING SOCIETY

The American Hearing Society and the American Speech and Hearing Association has adequately presented testimony regarding the national problem of the deaf and hard of hearing and those people who have speech difficulties.

Testimony in this report will be confined to the geographical location of Hudson County, N.J.

Subject matter presented in this testimony is as follows:

I. REHABILITATION

A. General presentment of problems pertaining to persons of all ages who are deaf and hard of hearing.

B. What is lacking in Hudson County, N.J.

C. What is needed in Hudson County, N.J.

D. Conclusion (see green pages—proposal submitted to Jersey City Medical Center, June 1958).

II. SPECIAL EDUCATION

A. General presentment of problems pertaining to preschool and school-age deaf and hard-of-hearing children.

B. What is lacking in Hudson County, N.J., pertaining to preschool deaf and hard-of-hearing children.

C. What is lacking in Hudson County, N.J., pertaining to the school-age deaf and hard-of-hearing children.

D. Conclusion: What is needed with recommendations and suggestions for the special education for the deaf and hard of hearing of preschool and school-age children.

I. REHABILITATION

A. History of the Jersey City Society and presentment of problem in Hudson County, N.J.

The Jersey City Hearing Society has been in existence since 1920. It is an affiliate of the American Hearing Society which has devoted and will always devote its efforts toward helping the deaf and hard of hearing.

The United States has 12 million people with impaired hearing; Hudson County has approximately 45,000; Jersey City has about 2,700. Statistics presented are based on reports read from the American Hearing Society which are based on incidence only. Many people with a hearing impairment, fearing a complete social readjustment, refuse to be helped. Unfortunately, many do not realize that their hearing is impaired and usually seek help and guidance when impairment is of a very serious nature. Without proper guidance they are affected psychologically; their normal communication is unintelligible; their speech becomes incoherent; thus, they gradually recede socially from every day society and most serious of all efficiency at their daily endeavor is reduced to a degree where the employer must terminate their services. With this occurring they become a burden to society and must seek guidance for rehabilitation.

B. What is lacking

Hudson County has a population of 650,000; based on opinion of experts for every 50,000 people there should be one speech and hearing clinic. Hudson County to date is without a speech and hearing clinic.

The Jersey City Hearing Society is the only agency in Hudson County where people might come for referral and guidance. Its services are very limited insofar as diagnostic and evaluation in workup are concerned simply because it cannot afford to pay qualified personnel. Its existence depends on an appropriation of \$2,000 per year from the United Community Fund. Pathetically to state both city and county hospitals refer some of their in and outpatients to Jersey City Hearing Society for referral and audiometric evaluation. The Jersey City Hearing Society has worked feverishly for the possible establishment of a speech and hearing clinic in both the Jersey City Medical Center and the county hospital. In each case it was reported that the necessary funds were not available.

C. What is needed

Must enact legislation whereby the State rehabilitation be given more financial aid. The following facts taken from reports submitted by the New Jersey State Rehabilitation Commission will present the picture statewide for all handicapped.

Analysis of caseload

	1955	1958	1959
Awaiting investigation at beginning of year.....	627	1,885	2,075
Total referrals on hand.....	2,484	6,432	6,118
Closed rehabilitated.....	619	1,030	1,316

This brief report shows definitely the need for more Federal financial aid for the State. In New Jersey population has been increasing to an extent that public health figures show 7,810 in New Jersey become disabled each year. Only 1 out of 6 cases receive vocational rehabilitation services. The public must be made to realize by rehabilitating the disabled the Government in turn will receive more taxes for a stronger economy and a healthier Nation. It is an established fact that every dollar spent on rehabilitation brings in \$10 in taxes due to an increase in productivity resources. Most important of all a human being has been guided where he is independent and not dependent.

II. SPECIAL EDUCATION

A. General presentment of problem

Unfortunately, in presenting testimony pertaining to the deaf and hard of hearing preschool and school-age children it is very difficult to offer statistics that would reflect the magnitude of our problem. Testimony is best presented by citing that in Hudson County, N.J., there isn't any place where parents of the preschool deaf and hard of hearing child can receive a complete diagnostic and clinical workup. The Jersey City Hearing Society offers a limited diagnostic workup which only includes audiometric tests and speech reading by nonprofessional personnel.

B. Preschool deaf and hard of hearing children

The education of the preschool deaf and hard of hearing child depends so much on a professional diagnostic and clinical workup. With this type of evaluation the parents and the child are guided properly. At this stage of the child's life it is of utmost importance that the parents as well as the child be helped. Parents must be taught to accept the child's handicap and should be taught to work together with the professional personnel of the speech and hearing clinic.

To date the preschool child in Hudson County is in serious need of a preschool nursery whose efforts will gradually be coordinated in with the local board of education. When the child is of school age the board of education will have a prepared case history of the child.

C. School-age deaf and hard of hearing children

I best offer testimony by stating that the school age child is being offered a very limited type of program. There is an urgent need for more competent teachers. I best exemplify by citing that in one of Hudson County's hard of hearing classes there are nine children representing five different grade levels. Under these conditions it is physically impossible for one teacher to devote the time necessary to teach the children properly.

D. Conclusion: What is needed to help solve the unmet needs in the special education field for the deaf and hard of hearing

Enact Federal legislation whereby grants may be given to States for the following needs:

1. *Survey.*—An accurate State survey of all handicapped in the country should be taken by a competent group of legislators, clergymen, laymen, agencies, and educators. Survey must have birth as a starting age.

2. *Research.*—Higher institution of learning to enter into research pertaining to the best methods of teaching the handicapped.

3. *Teachers.*—Based on research findings offer courses to teachers presently in the field and students entering the field.

4. *Public relations.*—To encourage municipalities to increase the salary pay scale of the present teachers and increase the basic pay rate of new teachers entering the field.

PROPOSAL FOR THE ESTABLISHMENT OF A SPEECH AND HEARING CLINIC AT THE JERSEY CITY MEDICAL CENTER

PROPOSAL

The establishment of a Speech and Hearing Center at the Jersey City Medical Center, with the possibility of being affiliated with the Seton Hall College of Medicine and Dentistry.

PURPOSE

At the present time, based on a survey made in 1949 and applying the percentages to the 1950 census figures, Hudson County has 45,500 hard-of-hearing people with about 4,000 of this group of school age. These figures are definitely on the conservative side.

Adequate facilities are not available for a complete diagnostic workup, as a result of this condition persons must go elsewhere.

Parents of preschool children with impaired hearing must take the youngsters out of town to get the proper diagnosis and therapy. This can be very discouraging as well as time consuming, as it entails visits three times a week in

training the children. This is exhausting physically for the child and financially for the parent.

Aside from the limited services offered by the Jersey City Hearing Society, older people have no other source of help in the entire county.

WHAT THE CLINIC COULD OFFER

I. Complete diagnosis to include:

A. Medical:

1. Otological analysis.
2. Medical or surgical treatment if indicated.

B. Audiological analysis:

1. Nature and extent of loss to be measured by:
 - (a) Pure tone audiometric test for hearing threshold.
 - (b) Speech reception threshold test.
 - (c) Speech discrimination threshold test.
 - (d) Recruitment test.
2. Extent of disability in terms of:
 - (a) Social adjustment.
 - (b) Psychological adjustment.

C. Rehabilitation:

1. Hearing aid selection.
2. Auditory training.
3. Lipreading.
4. Speech therapy.
5. Psychotherapy.
6. Followup in very difficult cases.
7. Instructions to parents or relatives.
8. Persons requiring speech treatment.
9. Nonprofit workshop.

D. Personnel:

1. Otologist—assumes responsibility for services as outlined under A.
2. Audiologist—assumes responsibility for services as outlined under B.
3. Secretary.
4. Volunteers.

Equipment (minimum)

1. Soundproof room No. 403 Ct-----	\$4, 500. 00
2. Allison of test instrument (pure tone air and bone conduction; speech reception and threshold; speech discrimination-recruitment-malingering)-----	4, 000. 00
3. Grason-Stadler model E-664, GSR-----	1, 000. 00
4. Grason-Stadler model 260B auditory training-----	1, 187. 00
5. Tape recorder-----	200. 00
6. Two sets records W-1, W-2, W-22; 33 $\frac{1}{3}$ r.p.m-----	6. 10
Total-----	11, 293. 10

FUNDS OR METHODS OF FINANCING

1. Fees for services.
2. Workmen's compensation and insurance.
3. United fund.
4. Other handicap agencies.
5. Board of education.
6. Vocational rehabilitation service.
7. Federal assistance, Public Law 565.

CONCLUSION

This outline should be given serious and complete study. Our community definitely must try to establish this proposed program. It gives only the minimum services needed in a city of this size, and should be included in the overall plan of the Seton Hall Medical School-Jersey City Medical Center.

STATEMENT BY DR. BOYD E. NELSON, DIRECTOR OF SPECIAL EDUCATION, NEW JERSEY STATE DEPARTMENT OF EDUCATION

Six years ago a child-by-child count was made of children in New Jersey public schools who were determined to be in need of special education services because of mental retardation and physical disabilities. No child was counted twice. About 4.6 percent of schoolchildren were reported as needing special education, and the study committee determined that about half of these could be properly served in regular school programs without special education. Therefore, about 2.3 percent of the total school enrollment was determined to need special education because of mental retardation and physical handicaps.

New mandatory legislation was enacted in 1954, and New Jersey made tremendous progress in developing new programs for handicapped children. Today, if the 2.3-percent figure still holds true, the New Jersey program is approximately 60 percent effective in terms of the categories of children included in the survey and who are receiving some type of special education. We do recognize that large numbers of this 60 percent are not receiving the most desirable type of special education, and that much is lacking in the quality of programs for those who are receiving appropriate special education.

During the past 5 years our National Congress has passed legislation to aid in the education of blind children; to develop research in the area of education for retarded children; to grant scholarships to persons training to supervise school programs for retarded children; and to develop and facilitate captioned films for the deaf. In each instance, certain administrative or supervisory responsibilities have been implied or assigned to the State Department of Education. In each instance it seems necessary in order to make even token and somewhat ineffectual gestures toward administering Federal aid, to further dilute already woefully lacking services which the department of education provides to handicapped children in general. To assume that State legislators will provide effective means to carry out the provisions of Federal Acts designed in the pattern recently established has proved complete folly, and may have done injury to overall programs for handicapped children in some instances. We do not deny that good may also have resulted in many instances. I see nothing in House Joint Resolution 494 dealing with training of teachers for the deaf and speech defective which deviates from this pattern to dissipate present administrative and supervisory services now provided handicapped children.

The most urgent needs in the field of special education, which includes rehabilitation, are first in the areas of administration and supervision. Without proper administration it is better to forget about serving needs regardless of their seriousness and numbers. Possibly to a greater extent than in any other field of education, severe administrative, supervisory, and teacher problems exist in special education. This is true in terms of services for exceptional children within local school districts, at the county level, within our colleges and universities, and at the State level.

The most ineffective first steps of which I can conceive for meeting needs in special education would be to adopt plans merely involving the granting of scholarships. Too frequently these scholarships go to—

(a) Persons who would go into special education regardless of scholarships.

(b) To persons who may not have been adequately screened due to ineffective administrative services.

(c) To persons who when once trained will find employment in more status giving administrative, supervisory, or teaching positions than those existing in the field of special education.

By far, greater numbers of teachers of handicapped children in New Jersey serve with emergency certification than in any other area of teaching. Needs, however, go much deeper than giving additional partial training to personnel who then often leave the field. Personnel desert or do not join the field of special education because their salaries and status often are not commensurate with their training; because they are not given sufficient and sympathetic supervision and inservice help; because they serve without adequate facilities.

Another point which has caused grave concern has been a superficial evaluation of needs according to category of handicapped. When we observe a superior program for our exceptional children in a school system, we almost always observe a good program which is providing services in a variety of categories. This program is good not because children have been classified into snug categories, but because a board of education has been concerned with the basic needs

of handicapped children in terms of administration, supervision, early identification, assessment of problems, quality of personnel, facilities, finance, research, followup procedures, inservice and other training opportunities, and inter-discipline and interagency cooperation.

STATEMENT OF JULIAN G. STONE, PRESIDENT, NEW JERSEY REHABILITATION
ASSOCIATION

My name is Julian G. Stone and I am president of the New Jersey Rehabilitation Association. Our association is vitally interested in H.R. 3465, which will create program and facilities for the severely disabled so that they may achieve independent living.

All studies of disabled persons in this country have indicated that there is a tremendous number of severely disabled individuals who do not meet the generally accepted standards presently established by the vocational rehabilitation services. Many of these people have applied for help and have been found to be ineligible. But they have rehabilitation needs, provision for which is not included in the current concept of vocational rehabilitation. They do not have vocational potential, according to the current standards.

It has become apparent, through intensive study of this problem, that many such severely disabled persons, if provided with proper evaluation and restorative services, may be found to possess varying degrees of vocational potential, who otherwise might have to accept objectives that do not include vocational achievement.

In 1958 alone, over 2,000 cases were rejected by the New Jersey Rehabilitation Commission as not eligible. We are convinced that in the State of New Jersey there are many more thousands of individuals who have unnecessarily been relegated to the human wasteheap. We strongly feel that such individuals should have an opportunity to make the most of their potentials without regard to what their ultimate accomplishments may be.

We believe that the addition of independent living rehabilitation services will result in a great improvement in the present vocational rehabilitation services. With proper evaluation, we are sure that many individuals who might be considered nonfeasible in terms of rehabilitation according to present definitions, will be found to have, if not full-time employment potential, at least part-time. By the same token, those who are accepted for vocational rehabilitation may be found to be unemployable and hence transferred to the independent-living program.

There are many benefits which would result from the independent-living program. I would like to mention a few:

(1) It will prevent the institutionalization of a significant number of handicapped people, thereby alleviating the overcrowded conditions of institutions and cutting down on their waiting lists.

(2) It could conceivably prevent the building of additional institutions, thereby saving the taxpayers considerable sums of money.

(3) It would relieve a member of the household of the responsibility for the constant care of the handicapped person, which might eventuate in obtaining outside employment, thereby adding to the family income.

(4) Last, but not least, it would mean the restoration of human dignity for the handicapped individual.

Mr. ELLIOTT. At this point I will state for the record and for our friends who are present this afternoon, that under the auspices of our Subcommittee on Special Education of the U.S. House of Representatives, a study which we call our special education and rehabilitation study, is being conducted. This study is being conducted through the mechanics primarily of workshops which are being held all over this country of ours.

One of these workshops was held the past 2 days in Philadelphia and we have present with us this afternoon the director of the special education and rehabilitation study and I would like for him to stand at this time. I refer to our friend, Dr. Merle E. Frampton, director of the study.

Dr. Frampton, will you stand and let the folks see you.

Dr. Frampton is a famous educator in this field. He works with our committee and cooperates with us as he goes about the work of gathering the information that we seek from all sections of America.

The assistant to Dr. Frampton, as the director of the study, is Dr. Elena D. Gall. Dr. Gall is professor of education at Hunter College and is the assistant to the director of our study in charge of field studies.

Dr. Gall's role in this matter has been to conduct the workshops over the country which I have mentioned, the latest of which just closed was Philadelphia.

I am told that several of the participants in the workshop must get away and at this time I am going to recognize Dr. Gall to call upon the people selected by the workshop to testify in its behalf.

For our record, Dr. Gall, and for the benefit of all of us will you tell us a word about how the workshop was set up?

STATEMENT OF DR. ELENA D. GALL, PROFESSOR OF EDUCATION, HUNTER COLLEGE

Dr. GALL. Mr. Elliott and members of the Subcommittee on Special Education, we are delighted this afternoon to bring to you the reports of the workshop which was held for the last 2 days in Philadelphia and which represents this region of the country; namely, the States of Delaware, New Jersey, Maryland, and Pennsylvania.

You can see by the assistance that I have received in filling out the total number of States which comprise this area the kind of cooperation that we have been extending to each other from State to State in the last 2 days.

The Eastern Atlantic Regional Workshop was held at the Institution of Local and State Government at the University of Pennsylvania and we divided our 180 participants into sections which are represented by the titles, "The Gifted and the Talented," "The Hearing Handicapped," "The Mentally Retarded," "The Physically Handicapped," "The Socially and Emotionally Handicapped," "The Speech Handicapped," and "The Visually Handicapped."

These are the seven areas about which we spoke and heard many, many types of information in the last 2 days.

If you had been present at the Fells Institute you would have seen small groups of leaders in this part of the country voice their opinions, bring information, disagree with each other, and then later perhaps have a meeting of the minds.

All of this information will be reported in the final compilation of reports which will be made available to your committee, Mr. Elliott.

But this afternoon it gives me a great deal of pleasure to tell you that there are representatives of these various workshops present who will give you a summary of their deliberations.

They will tell you that in their workshops they have had many disciplines represented, psychiatry, medicine, psychology, education, school administration, family group representatives, parent representatives, labor, and law; they were all together in setting up the kind of recommendations that they thought your subcommittee might want

to need and study in order to form your own opinions about the unmet needs of this particular geographic region.

Most of our participants came on their own expense and used their own valuable time in order to bring this information to you.

Many worked until very late last evening and some completed their reports at 8:30 this morning.

It gives me a great deal of pleasure, Mr. Elliott, to tell you that our fourth field study, our regional workshop in this region, was one of the most successful we have held.

I will let you have the list of names of those who are representing their particular workshops. All of them are here.

Mr. ELLIOTT. Thank you very much, Dr. Gall.

You know, this was the fourth workshop, Dr. Frampton. The report I get is that each is better than the one before.

So I feel that they are going very well and we are happy about it.

Before I call the witnesses from the workshops, let me say that if there is anyone who just has to get away by 4 o'clock or 4:30, or a particular time, if he will let Dr. Barnard or Miss Alice Hartman know, I will try to accommodate him as I call the witnesses.

The first witness on our list is Dr. Georgia Lightfoot, State Supervisor of Special Classes, State Department of Public Instruction, Dover, Del.

How are you, Dr. Lightfoot?

Dr. LIGHTFOOT. Fine, thank you, Mr. Chairman.

Mr. ELLIOTT. Dr. Lightfoot comes to you as representative of the group on the gifted and the talented.

You may proceed, Dr. Lightfoot, and at the end of 10 minutes I may have to tell you that the time has expired.

STATEMENT OF DR. GEORGIA LIGHTFOOT, STATE SUPERVISOR OF SPECIAL CLASSES, STATE DEPARTMENT OF PUBLIC INSTRUCTION, DOVER, DEL.

Dr. LIGHTFOOT. As have the others, gentlemen of the Congress of the United States, this particular section is cognizant of the great honor we have and a great opportunity to present the cause of the gifted children of America.

We realized that we did not know all the unmet needs, but we found some that were self-evident.

We would like to have you keep in mind with us that true democracy as applied to education means the opportunity for all individuals to develop each of them to the utmost of his own inborn potential.

Such an opportunity has not been afforded. It has even been denied to many gifted and talented people.

It is not true that they can take care of themselves and it may have become a cliché almost by now to say America's most neglected natural resource, nevertheless, that is true and we are the losers for having so neglected them.

We then are grateful for the chance to make an effort to rectify that situation, and hope you will consider this cause carefully among the others.

I am honorbound to report faithfully in the phrasing of the members of the committee the recommendations that they had to make.

First they place this one: Financial assistance should be given by the Federal Government to the States for the purpose of furthering the inservice education of teachers, an area of educating the gifted through workshops and fellowships. The appropriations suggested is \$1 per year per child enrolled in the public school system for the next 5 years.

We feel the unique aspect of our recommendation here is that we are asking for further answer of the education of all teachers, not just a segment to be known as the teachers of the gifted.

This because we are all too well aware that there are some teachers who do not recognize gifted children when they see them.

Our second recommendation, title V of the National Defense Education Act, should be extended in the elementary school on the same financial and operational basis as is now provided at the secondary level in order that gifted children be identified as early as possible.

We felt very strongly about this. It is indeed a mistake to wait until of high school age before we identify our gifted and do something about them.

The time is when they are 2 and 3 years of age, or 4 or 5 or 6 at the latest.

Mr. ELLIOTT. Doctor, do you not think we have made a little bit of progress in that direction when we made a start 2 years ago?

Dr. LIGHTFOOT. You certainly did, and we are happily aware of this. We do not mean to be grasping. We are just urging you to go even further, hoping that we have brought this to your attention. It indeed was a most important start.

Mr. ELLIOTT. Do you think we need next to bring those facilities and aids to the grammar school? Is that what you are saying?

Dr. LIGHTFOOT. Yes, indeed.

Mr. ELLIOTT. Do you think down below the school level?

Dr. LIGHTFOOT. Yes.

Our third recommendation, \$3 million annually for a period of 5 years should be appropriated by the Federal Government on a matching basis for the development of experimental programs and for strengthening existing programs for the gifted. We feel that there are a number of isolated experiments, that there should be many, many new ones, but there are some good programs underway. They are going to fall by the wayside, however, unless they get more financial assistance than is now possible to them from local sources.

Four, matching funds should be appropriated on the same basis as now provided in other areas under title III of the National Defense Education Act for the purchase of library and other instructional materials to improve the education of the gifted in the humanities broadly conceived in order to promote the development of social and political leaders.

We feel that it is just as important to develop statesmen like yourselves as it is perhaps experts in physics and chemistry.

Five, grants to total \$3 million should be appropriated annually over a period of 5 years to conduct research in the following areas:

A. Identification of the gifted;

B. Determination of the needs of the gifted;

C. Programs of education of the gifted.

D. Motivation of the gifted.

E. Nature of creative, critical thinking and leadership potential;

F. Administrative organization for education of the gifted.

Six, all research on the gifted should be coordinated by the U.S. Office of Education.

Seven, a commission should be appointed to study the function of the U.S. Office of Education for the purpose of determining ways in which it can stimulate the improvement of the education of the gifted.

These, we felt to be the outstanding unmet needs. We should establish, I think, that the recommendations made for appropriations are based on the estimate of approximately 3 million children enrolled in the public schools of the four States comprising the eastern Atlantic region, Delaware, Maryland, Pennsylvania, and New Jersey.

We have a final remark. The members of this section trust that the Congressmen will bear in mind that the gifted do not belong in the category of the handicapped and, therefore, we are all concerned with the development of appropriate educational patterns and opportunities for exceptional children of high mental ability. Thank you very much for your attention.

Mr. ELLIOTT. Thank you very much, Dr. Lightfoot.

May I recognize the gentleman from Connecticut, Mr. Giaimo.

Mr. GIAIMO. Did you say that you felt that the gifted did not belong in the category of the handicapped?

Dr. LIGHTFOOT. Yes. There are individuals who have physical handicaps, perhaps a handicap of emotional disturbance possibly, who are also gifted.

If there is any handicap it is not because of a mental ability, but regrettably they sometimes are handicapped by this high level because of the way they are treated in our society, the group in which they find themselves.

Mr. GIAIMO. Then do you think that the gifted would suffer by being included in a projected program dealing with the handicapped, would suffer in the sense that perhaps they might not be able to show that their need for priority type of legislation, for example, would be as great?

Dr. LIGHTFOOT. This classification troubled members of the committee, our workshop group, to the degree that they also argued this very point.

Should we not get it established that they should be treated by themselves. Certainly they did want the idea clear that they were in a separate category, or did not belong in the category of being handicapped.

They are perhaps fortunate in their endowment, but they have suffered on occasion because of high endowment and particularly at an early age and the result of this has been that they have not achieved and produced to the degree that they might otherwise have done so in a more friendly climate, not a hostile one, or with more assistance.

And sometimes outright financial assistance.

This is why we particularly feel that teachers of all types need this further instruction in particular kinds of workshops to improve their attitudes toward the gifted, to gain insight as well as knowledge of how to meet their needs.

Not for one moment however, do we want to take any chance of their failing to receive assistance.

Mr. ELLIOTT. Thank you very much, Dr. Lightfoot.

Dr. LIGHTFOOT. Thank you, Mr. Elliott.

(The formal report referred to follows:)

REPORT OF EASTERN ATLANTIC STATES WORKSHOP ON THE GIFTED

Chairman: Dr. Georgia F. Lightfoot, State supervisor of special classes in Delaware, representative of this workshop reporting to the subcommittee hearings, February 17, 1960.

Cochairman: Dr. Geneva Ely Flickinger, Maryland State supervisor of special education.

True democracy, as applied to education, means the opportunity for each individual to develop to the limit of his inborn potential. Such an opportunity has not been afforded, it has even been denied to many gifted and talented people.

The members of this section on the gifted of the Eastern Atlantic States Workshop are grateful for the chance to make an effort, at least, to rectify this situation.

At the outset of our deliberations, we realized that we did not know all the unmet needs of the gifted and talented, but on the basis of those lacks that were obvious, the "unmet needs" that were most evident, the members of this group agreed on these recommendations:

1. Financial assistance should be given by the Federal Government to the States for the purpose of furthering the in-service education of teachers in the area of educating the gifted through workshops and fellowships. The appropriation suggested is \$1 per year per child enrolled in the public school system for the next 5 years.

2. Title V of the National Defense Education Act should be extended into the elementary school on the same financial and operational basis as is now provided at the secondary level, in order that gifted children be identified as early as possible.

3. Three million dollars annually for a period of 5 years should be appropriated by the Federal Government on a matching basis for the development of experimental programs and for strengthening existing programs for the gifted.

4. Matching funds should be appropriated, on the same basis as now provided in other areas under title III of the National Defense Education Act for the purchase of library and other instructional materials to improve the education of the gifted in the humanities (broadly conceived), in order to promote the development of social and political leaders.

5. Grants totaling \$3 million should be appropriated annually over a period of 5 years to conduct research in the following areas:

- (a) Identification of the gifted.

- (b) Determination of the needs of the gifted.

- (c) Programs of education of the gifted.

- (d) Motivation of the gifted.

- (e) Nature of creativity, critical thinking, and leadership potential.

- (f) Administrative organization for education of the gifted.

6. All research on the gifted should be coordinated by the U.S. Office of Education.

7. A commission should be appointed to study the function of the U.S. Office of Education for the purpose of determining ways in which it can stimulate the improvement of the education of the gifted.

The recommendations for appropriations are based on the estimate of approximately 3 million children enrolled in the public schools of the four States comprising the Eastern Atlantic Region, Delaware, Maryland, Pennsylvania, and New Jersey.

The members of this workshop section trust that the Congressmen will bear in mind that the gifted do not belong in the category of the handicapped, and therefore we are all concerned with the development of appropriate educational patterns and opportunities for exceptional children of high mental ability.

Mr. ELLIOTT. Our next witness is Miss Elizabeth Titsworth, assistant superintendent, New Jersey School for the Deaf. She will give the

report of the workshop on the section entitled the Hearing Handicapped.

Miss Titsworth.

STATEMENT OF ELIZABETH TITSWORTH, ASSISTANT SUPERINTENDENT, NEW JERSEY SCHOOL FOR THE DEAF, WEST TRENTON, N.J.

Miss TITSWORTH. Mr. Elliott and members of the committee, our report is in this form. They considered the hearing problem of the young child, school age child, and the adult.

Mr. ELLIOTT. Before you get started, let me also say that our witness is the assistant superintendent of the New Jersey School for the Deaf in West Trenton, N.J.

Miss TITSWORTH. The thinking was that there is one person in a thousand who is severely deaf and three in a thousand who have mild or moderate hearing loss.

The greatest problem is that there is inadequate and insufficient training staff.

It was highly recommended that before Federal funds are expended authorities in professional national organizations have some consulting status. There are such things that come up as a difference between a clinician and a teacher of the deaf.

The clinician is charged with the responsibility of training the hearing impaired in speech and in hearing rehabilitation, whereas the teacher of the deaf is responsible for teaching subject matter, developing language and speech and training of hearing.

Some of the needs that are being met in various ways are the detection being carried on by the school screening program. There is referral by individuals and professional organizations and the child health programs are referring.

In the health services there is good diagnosis and evaluation and in the educational phase of it we have the State-supported residential schools, the day schools in local districts, day classes in local districts, and private and denominational schools.

For professional training there are the institutions for the preparation of teachers and for the preparation of allied personnel. There are definite lacks in case detection and identification. Something that needs to be worked out is uniformity of procedures and equipment used. Also, there is a shortage of trained personnel for detection and identification, and lack of personnel for appropriate followup.

In the health services there is a shortage of personnel in regard to rehabilitation workers and followup and in recruiting of personnel.

In the educational field there is a definite shortage of personnel, both for teachers and allied personnel.

The multiple handicapped child has entered into the picture and this is a place where there needs to be study and a development of building up of personnel for teaching and understanding of this child.

Research will probably come in at this point and this is a place where we need to extend the program throughout the Eastern States.

In the educational field only a fraction of the hearing impaired children's needs are being met by trained persons. It is a serious

need that funds be provided for training classroom teachers and administrative personnel at all educational levels.

The research program should provide for dissemination of research findings to classroom teachers, administrators, and allied personnel.

In most cases at present such findings are extremely limited. There is a need for expansion and expansion of research in regard to the multiple handicapped should include the incidence, the diagnosis, medical treatment, educational needs, administrative management and standards for such a program.

The needs of preschool children must be explored and expanded. As we have learned of late, children under four who are deaf benefit greatly from an educational program. In some States the school entrance age is four and it is necessary to reach down to the 2- and 3-year-old children.

Another phase that was discussed was that of rehabilitation. It was recognized that there is a group of people with hearing problems that are developing due to industrial deafness. It certainly calls for research and taking steps that will prevent this.

Secondly, it was felt that there are gaps in the vocational training of the deaf and hard of hearing and it was advised that we have to reach down to the age of 12 and 13 as a possible beginning for educational consultants in vocational lines.

There was a discussion of the geriatric aspects of hearing impairment. At present there are 10 homes for the aged deaf in existence which are maintained by various organizations of the deaf. Indications are that more will be needed.

Also, as far as vocational rehabilitation is concerned, the multiple handicapped needs help and their possibilities need to be researched along those lines.

It is recommended that sheltered workshops be provided for meeting the need of some of the multiple handicapped.

Mr. ELLIOTT. Thank you very much, Miss Titsworth.

(The formal statement of Miss Titsworth follows:)

WORKSHOP REPORT ON THE HEARING IMPAIRED

Cochairmen:

Lloyd A. Ambrosen, superintendent, Maryland School for the Deaf representing special education.

Dr. William G. Hardy, director, hearing and speech center, Johns Hopkins medical institutions, Baltimore, Md., representing rehabilitation.

Corecorders:

Dr. Powrie V. Doctor, editor, American Annals of the Deaf, Gallaudet College, Washington, D.C.

Richard B. French, coordinator of speech and hearing services, Delaware Department of Public Instruction, 17th and Union Streets, Wilmington, Del.

Workshop participants:

Francis I. Catlin, M.D., associate professor of otolaryngology, Johns Hopkins medical institutions, Baltimore, Md.

Sam B. Craig, superintendent, Western Pennsylvania School for the Deaf, Edgewood, Pittsburgh, Pa.

Leo G. Doerfler, director, department of audiology, University of Pittsburgh, Pittsburgh, Pa.

Eldon L. Eagles, M.D., director of field studies, subcommittee hearing academy of otolaryngology, University of Pittsburgh Graduate School of Public Health, Pittsburgh, Pa.

Sarah Goldberg, president of the board, Friends of the Deaf Nursery School, 1516 W. Girard Avenue, Philadelphia, Pa.

John G. Nace, headmaster, the Pennsylvania School for the Deaf, Philadelphia, Pa.

Marion L. McVeigh, associated regional representative, region II, Office of Vocational Rehabilitation, 42 Broadway, New York, N.Y.

Dr. Salvatore G. D. Michael, regional representative, U.S. Office of Vocational Rehabilitation, New York, N.Y.

L. Dino Reed, Dr. Sci., audiological consultant, division of maternal and child health, Pennsylvania Department of Health, Harrisburg, Pa.

Jean Stifter, M.D., chief, division for crippled children services, State department of health, State Office Building, Baltimore, Md.

Elizabeth F. Titsworth, assistant superintendent, New Jersey School for the Deaf, Trenton, N.J.

Dr. Peter R. Wisher, chairman, department of physical education, Gallaudet College, Washington, D.C.

Allan B. Jones, State supervisor, bureau of vocational rehabilitation, Harrisburg, Pa.

Joseph Sataloff, M.D., director of research, Jefferson Medical College, Philadelphia, Pa.

Margaret McCormick, principal, Willis and Elizabeth Martin School for the Deaf, Philadelphia, Pa.

Participants representing the Eastern Atlantic Region on Hearing Impairment met from 10 a.m. to 4 p.m. on February 16 and 17 at Fels Institute on Social and State Government, University of Pennsylvania, Philadelphia.

REPORT ON SPECIAL EDUCATION

Incidence

1. The incidence of hearing impairment is of such nature that increased services personnel, and research are needed on a scale requiring much greater efforts. The incidence is believed to be 1 in 1,000 for the severely hearing impaired (deaf) and 3 in 1,000 for mild to moderate hearing impaired (hard of hearing). Due to increasing population, medical science and improved diagnostic procedures and general public interest in special education; these figures represent, at best, conservative estimates. Many children are being saved who formerly succumbed, but at the expense of sensory performance and capacity to learn.

Adequacy of present services

2. We do not have adequate personnel or services to meet the needs of all hearing impaired children in the eastern Atlantic region. In addition to the need for sufficient personnel and services problem, the scarcity of adequately trained personnel is our most serious problem.

GENERAL STATEMENTS

It is highly recommended that before Federal funds are expended authorities in professional national organizations have some consulting status.

The distinction between a clinician and a teacher of the deaf must be clearly kept in mind. The clinician is charged with responsibility of training the hearing impaired in speech and hearing rehabilitation, whereas the teacher of the deaf is responsible for teaching subject matter, language and speech development and aural rehabilitation.

One of the most urgent needs in the area of deafness is in the field of public opinion and especially in allied groups. Professional people such as these in psychology, sociology, nursing, medicine, teacher training, and public school personnel should be made aware of the problems in this area, even to the extent of Federal money being spent for such purposes.

Some of the needs being met in varying degrees at the present time are represented in the following areas:

1. Detection:

(a) School screening programs.

(b) Referrals from individuals, professional agencies, and individuals.

(c) Child health programs:

Public.

Private.

2. Health Services:
 - (a) Diagnosis and evaluation.
 - (b) Medical, audiological, and psychological.
3. Diagnostic Services:
 - (a) Schools.
 - (b) Colleges and university hearing and speech centers.
 - (c) Hospital speech and hearing clinics.
4. Education:
 - A. School facilities:
 - (1) State supported residential schools.
 - (2) Day schools in local districts.
 - (3) Day classes in local districts.
 - (4) Private and denominational schools.
 - B. Professional Training:
 - (1) Preparation of teachers.
 - (2) Preparation of allied personnel.

The deficiencies in the above programs are as follows:

1. Case detection and identification:
 - (a) Diagnostic criteria (uniformity of procedures and equipment).
 - (b) Training of personnel.
 - (c) Appropriate followup.
2. Health services:
 - (a) Rehabilitation workers.
 - (b) Followup.
 - (c) Personnel.
 - (d) Facilities and equipment.
 - (e) Multiple handicaps.
 - (f) Recruitment of personnel.
 - (g) Standards in all areas.
3. Diagnostic.
4. Educational:
 - (a) Personnel.
 - (b) Multiple handicaps.
 - (c) Training facilities.
5. Research:
 - (a) Dissemination of information.
 - (b) Lack of adequate research in terms of personnel and programs.
6. Multiple handicaps (a child who has, in addition to the major handicap of impaired hearing, other educationally handicapped conditions):
 - (a) Incidence.
 - (b) Diagnosis.
 - (c) Medical treatment.
 - (d) Education.
 - (e) Administration.

Recommendations of the workshop to the subcommittee are:

1. Case detection and identification:
 - (a) Recruitment and training of personnel for case finding and identification:
 - (b) Recruitment and training of supervising personnel.
2. Health services:
 - (a) Increase in personnel in all areas.
 - (b) Assistance in upgrading facilities and personnel.
 - (c) Assistance in establishing standards and criteria for all areas.
 - (d) Diagnostic.
 - (1) Criteria in diagnosis covering medical, psychological, and educational findings and recommendations.
3. Educational:
 - (a) With only a fraction of the hearing impaired children needs being met by trained personnel a most serious needs is for funds to provide training for classroom teachers and administrative personnel at all educational levels.
 - (b) Personnel with adequate training to meet the needs of multiple handicapped children is most urgent.

4. Research:

- (a) A program providing for dissemination of research findings to classroom teachers, administrators and allied personnel. In almost all cases dissemination of such findings is extremely limited.
- (b) Extension and expansion of research into multiple handicaps covering:
 - (1) Incidence.
 - (2) Diagnosis.
 - (3) Medical treatment.
 - (4) Educational needs.
 - (5) Administration and management of programs.
 - (6) Standards in programs.
- (c) Preschool children.
- (d) Hearing-impaired children having language disorders.
- (e) Language disorders in other children.
- (f) Validation of training procedures for hearing-impaired children.
- (g) Social adjustment problems of adolescent hearing-impaired children.

5. Multiple handicaps:

- (a) Diagnosis.
- (b) Incidence or census procedures.
- (c) Proper medical treatment.
- (d) Education programs appropriate for these children.

PROBLEMS OF HEARING IMPAIRMENT—REPORT ON REHABILITATION

The group chose to treat the problems of rehabilitation as differently oriented than those of special education. Whereas it was recognized that there is clearly a continuing need for each family to maintain responsibility for its own problems, it was recognized, as well, that several aspects of rehabilitation of the deaf and the hard of hearing present unmet needs which could be met by support for both training and research at the national level.

First, rehabilitation counselors commonly have little awareness or understanding of hearing problems, and relatively little awareness of the broad health aspects, and the health services available, which should be considered at the level of differential diagnosis, management, training, and followup toward rehabilitative goals. The group recommends that the training and education of rehabilitation counselors should be intensified and broadened in all aspects of the special needs of hearing-impaired persons. Special training units and grants might well be made available to rehabilitative personnel for short-term courses.

Second, it was felt that there were many gaps in the steps between early vocational training in school and later specific requirements of the individual at the level of job placement. To fill this gap, it is recommended that extensive joint planning be undertaken between personnel in rehabilitation (and in health services, as pertinent) and in special education. This would involve the use of rehabilitation counselors as consultants during the school years from age 12-13 on, and possibly the use of educative consultants later on. This step might well entail changes in current State laws.

Considerable time was spent in discussion of various aspects of the problems of industrial noise. There is ample evidence that this is a massive problem, involving millions of adults. The scope and magnitude of the problem of noise in industry cannot be overemphasized in terms of lost man-hours, of lessened income, of the level of work output, and on problems of long-term compensation for the affected person. Because of the many ramifications for industry, labor, insurance, and rehabilitation, an extensive research inquiry including all these interests is clearly indicated. It becomes apparent that one possible and important solution to the general problem centers in prevention. This will require an extensive program of education. Meantime, it is felt that government and other appropriate agencies could do much to originate and enforce safety regulations and practices to control the hazards of industrial noise.

Fourth, there was long discussion of the geriatric aspects of hearing impairment. There are some 10 homes for the aged deaf in existence which are maintained by various organizations of the deaf. Many more are needed. It is particularly important that these persons remain in contact with both hearing and deaf adults. To this end, it was suggested that room be made for the aged deaf in homes for mixed groups. Moreover, a need was expressed for research

into the behavioral, social, and emotional effects of hearing impairment on the adult, both the deaf and the hard of hearing. Very little has been accomplished in this regard, and the dearth of information directly effects both vocational and geriatric aspects.

The last general topic discussed had to do with the multiple handicapped persons. In this regard, the term "multiple handicapped" refers to a person who has in addition to a major handicap in hearing other handicapping conditions. The group recommends that an appropriate survey (not a census) be undertaken to determine the number of such multiple handicapped persons in the country. No single professional group has access to such a figure. Without it, it is practically impossible to consider seriously the kinds and numbers of personal and special facilities required.

There were a few specific ideas related to different aspects of the problems of hearing impairment. First, the need for research on curriculum and methods of vocational instruction for deaf persons. Second, the possible use of regional vocational training schools for the deaf, staffed with persons trained to teach the deaf in various shop practices. Rehabilitation counselors can find the necessary jobs, but the individual must first have the necessary skills; they cannot be learned by on-the-job training. Third, the need to alert industry to the potential in supervisory and administrative positions of the deaf; this, too, probably requires a public educative program.

MR. ELLIOTT. Our next witness comes from the section on the mentally retarded of the Philadelphia workshop and that witness is Dr. Harry Selznick, of the Department of Special Education, Baltimore Public Schools, 3 East Twenty-fifth Street, Baltimore 18, Md.

STATEMENT OF DR. HARRY SELZNICK, DEPARTMENT OF SPECIAL EDUCATION, BALTIMORE PUBLIC SCHOOLS, BALTIMORE, MD.

DR. SELZNICK. Mr. Elliott and gentlemen of the U.S. Congress, I have just completed a very stimulating and challenging 2 days in Philadelphia and would like to have these few moments to share with you the experiences through which we have just passed.

I particularly would like to share it with my colleague from back in the Midwest, having formerly lived in Minnesota at one time.

So I feel an akinness to Mr. Quie.

MR. ELLIOTT. Now, before you get started, are the recommendations that you are going to bring us substantially unanimous from your group?

DR. SELZNICK. Sir, I am relaying the recommendations of the group which are the consensus rather than unanimous in nature.

We tried to make our recommendations as realistic as midwesterners can possibly make them.

MR. QUIE. That shows he is from Paul Bunyan land.

DR. SELZNICK. Included in our group were persons from special education, including residential and public school settings, rehabilitation, social work, psychiatry, psychology, and our first recommendations dealt directly with meetings such as those in which we directly participated.

We feel that by a provision of an opportunity for persons of the various disciplines to get together this committee has already provided a valuable function to the special education and vocational rehabilitation personnel of the eastern Atlantic region.

We feel that not only did we have an opportunity to share problems, to discuss unmet needs, but also to point toward bright signs in services to the mentally retarded and also permitted us an opportunity to suggest to honorable bodies such as this the kinds of legisla-

tion which would better permit us to do the job with which we are entrusted.

As was suggested by several of the others groups, of the major needs in the area of the mentally retarded, two relate to personnel.

It is our suggestion that rather than direct major appropriations to surveys in an effort to locate the size of the problem, that we direct our major energies toward the development of personnel who can meet the problem as it is located and provide meaningful learning experiences for these persons at the level at which they are capable of benefiting, the experiences to be provided at both graduate and undergraduate levels in meaningful amounts, and there was some discussion also of appropriations for fellowships which are not being requested because the amounts are such that the individuals cannot afford to accept fellowships to go on to the training programs to equip other persons in special education.

Another recommendation related to providing opportunities for short-term workshops, to improve interdisciplinary and interagency approach to the adjustments of the mentally retarded, increased support for both faculty students and inservice facilities to persons representing all disciplines working with the mentally retarded.

There is a request for training of consulting teams to act with existing or projected facilities and for inservice training in institutions and agencies.

There was an emphasis placed on the need for providing diagnostic and evaluation clinics and service to both urban and rural localities.

The need for strengthening and expanding existing services which are brought into the homes by public health nurses, by visiting teachers, and by social workers.

This particularly related to the management factor, the management stage and development of the mentally retarded child.

It is the recommendation of this group that legislation be amended to make it possible for the OVR to provide consultation and guidance for special educational personnel and parents of retarded children regarding training and long-range vocational planning for retarded youth.

The specific age that was suggested was age 13. Occupational training as a part of a sequentially developed program now not available in many public school systems could be implemented and strengthened by OVR.

At the present time in most States OVR does not step in until age 16. It was felt that assistance should be provided at an earlier stage.

Federal assistance for the establishment of occupational training workshops to supplement public school programs, to train educable mentally retarded for job placement and independent living.

Federal assistance was suggested for the establishment of sheltered workshops to serve as long-time permanent placement for the severely handicapped. This is in reference to the kinds of workshops about which we have heard today basically being sponsored by parent groups.

They have demonstrated the need.

The question is, now, where does the responsibility for maintaining such activities rightfully belong.

Assistance to States for the establishment of regional institutional programs was also pointed up.

These programs would provide day care training.

In the area of research there was recommendation that through increased Federal support, both clinical research, understanding of causative factors of mental retardation could be achieved.

There ought to be some Federal subsidy to find some more definitive diagnostic techniques and evaluative devices than are now available to professional personnel.

In the area of coordination it was recommended that an evaluation be made of the functions of the many Federal, State, and local agencies and disciplines which provide for mentally retarded children and youth to determine whether or not a more effective organization of these efforts could be achieved.

It was pointed up that there are over 20 agencies now involved in work with the mentally retarded, that there is already an interagency committee operating for children and youth which might serve as a facilitating instrument toward this purpose.

Also, facilitating the exchange of information among States and between States and the Federal Government for maximum use of available information and experience, and that responsibility quite possibly ought to be localized in the agency which has overall responsibility for the work with mentally retarded and also a recommendation for intensified effort to make known to the professions the present programs and sources of support at the Federal level.

During the course of our discussions we learned that some supports, with which not all participants in this meeting were familiar, were available and quite possibly a compilation should be made available to all persons so they know what is available as they try to identify unmet needs.

Thank you very much.

Mr. ELLIOTT. Thank you, sir.

WORKSHOP REPORT ON THE MENTALLY RETARDED

The section representing the States of the eastern Atlantic region and including diverse disciplines, special education, rehabilitation, social work, psychiatry, psychology, first wishes to point to the advantages of this kind of exchange and the review of common problems. Workshops of this type might well be encouraged. These meetings under the official auspices of the House of Representatives provide not only an opportunity for coordinated program planning, but also an opportunity to transmit the recommendations of professionals in this field to those who write legislation.

From the exchange we learned that good programs are in existence in all of our States, although these are by no means adequate to the problems. The major problem area which requires Federal stimulation is that of trained personnel. It remains true that an increase in basic services is necessary in order to meet the needs, but until the personnel are available additional funds for services will not solve the problem.

Accordingly, our first recommendation has to do with the need in the area of professional personnel. Each of the participating States has conducted incidence surveys which might be used to arrive at an estimate of the numerical size of the problem facing us at each level; diagnosis, education, and rehabilitation.

Before discussing more specific needs and recommendations, it should be noted that mental retardation is a condition involving very different age groups, etiologies, multiple handicaps, and ability levels. A proper program requires the coordinated efforts of many disciplines. This requirement is reflected at all levels (Federal, State, and local) by the participation of many agencies in programs affecting the retarded. At the Federal level it is recommended that

greater coordination be achieved through existing administration channels (such as the Interdepartmental Committee on Children and Youth) in order to clarify the programs in existence and to identify gaps and reduce overlap.

Development of adequate personnel, in quality and quantity, starts with recruitment to community service and the professions at the high school level. Dramatic and stimulating beginnings could lead students to dedicate themselves to the long process of training which may ultimately result in the members of the professions involved in diagnosis, treatment, education, and rehabilitation. This implies improvement of the educational effort prior to specific programs designed for the undergraduate and postgraduate areas. Increased Federal stimulation of programs designed to produce the needed specialists might well follow the pattern of the Defense Education Act. Additional programs are desirable which utilize experienced individuals and training situations in order to bring these understandings to others who have finished their training and to young people in training to familiarize them with the opportunities in the field. This suggests higher level support for special inservice training programs open to other appropriate personnel.

SERVICES

The need for improving existing facilities and knowledge should be met systematically and not by simple multiplication of present facilities. We endorse the following program:

1. Strengthening existing facilities in terms of staff, research, and treatment.
2. Utilize, where practical, existing facilities for teaching and training.
3. Improvement of services on a qualitative basis by encouraging development of staff and physical facilities designed to meet the needs; improved coordination of agencies offering independent services in overlapping need areas; and the support of developments in community services aimed at prevention.
4. As the effects of these steps are felt, it should become possible to expand facilities more meaningfully.

RESEARCH

We agree on the encouragement of research efforts at understanding the causes of mental retardation. Increased support (might well) be given to the improvement of differential diagnosis on an interdisciplinary basis and to experimental development of treatment and educational methodologies.

RECOMMENDATION—PERSONNEL NEEDS

1. Increase support and expansion of university training facilities on undergraduate, graduate, and postdoctoral levels for all disciplines concerned with problems of the mentally retarded.
2. Encourage specialization on the graduate level through the provision of adequate scholarships.
3. Provide opportunities for short-term workshops to improve interdisciplinary and interagency approach to the adjustment of the mentally retarded.
4. Increase support both for faculty and students for inservice training facilities for personnel representing all disciplines already working with the mentally retarded.
5. Training of consultant teams to act with existing or projected facilities and for inservice training in institutions and agencies.
6. Increase support to facilitate greater coordination between university and field training centers.

STRENGTHENING SERVICES

1. Provide diagnostic and evaluation clinics and services to both urban and rural localities.
2. Establishment of comprehensive day-care centers for those whose needs are not met under public school auspices.
3. Strengthen and expand existing services brought into the homes by public health nurses, visiting teachers, and social workers.

WE RECOMMEND

1. Amended legislation to make it possible for OVR to provide consultation and guidance for school special education personnel and parents of retarded children regarding training and long-range vocational planning for retarded youth from an earlier age. Occupational training as a part of a sequentially

developed program, now not available in many school systems, could be implemented and strengthened by OVR.

2. Federal assistance for the establishment of occupational training workshops to supplement public school programs to train educable mentally retarded for job placement and independent living.

3. Federal assistance for the establishment of sheltered workshops to serve as longtime terminal placement for severely handicapped.

4. Assistance to States for the establishment of regional institutional programs where needed. These programs would provide day-care training; strengthen training programs within existing institutional facilities by providing for competent inservice training and research personnel.

RESEARCH

1. Strengthen through increased Federal support, both basic and clinical research—

(a) Aimed at clearer understanding of causative factors in mental retardation.

(b) Aimed at better testing methods, having as their goal more precise classification of mentally retarded patients which could in turn make significant improvement in diagnosis, management, and results.

Such support should be made more readily available both administratively and to a broader spectrum of investigators.

Research in evaluation of educational methodology and training programs.

COORDINATION

1. Evaluate the functions of the many Federal, State, and local agencies and disciplines which provide for mentally retarded children and youth to determine whether or not a more effective organization of these efforts can be achieved.

2. Facilitate the exchange of information among States and between States and the Federal Government for maximum use of available information and experience.

3. Intensify efforts to make known to the professions the present programs and sources of support at the Federal level.

Cochairmen :

Dr. Harry Selznick, director, Department of Special Education, Baltimore Public Schools, 3 East 25th Street, Baltimore 18, Md.

Dr. Mortimer Garrison, Jr., director of research, Woods School, Langhorne, Pa.

Our next report comes to us from the section on the physically handicapped, of the workshop at Philadelphia.

That report will be made by Mr. William Page, of the Kessler Institute for Rehabilitation, of West Orange, N.J.

STATEMENT OF WILLIAM PAGE, KESSLER INSTITUTE FOR REHABILITATION, WEST ORANGE, N.J.

Mr. PAGE. Thank you very much, Mr. Chairman and members of the committee. Like my colleague who preceded me a few minutes ago, I wish there was some way in which we could have had you good members of this committee with us during the 2 days that my co-chairman, Dr. Leon Reid, associate professor of speech education of the University of Pittsburgh, and I conducted a workshop discussion for some 66 members of the overall special education and rehabilitation team throughout our 4-State area.

I think you can understand it becomes a rather formidable task to convey to you both the climate and certainly some of the substance of what was discussed at that time.

I would like to somewhat depart from the text of the report which is preliminary in nature that I would like to leave with the committee

today, to perhaps hit some of the highlights and let you know what we were thinking about and how that thinking process developed.

The workshop committee unanimously recommended that the Federal program of rehabilitation for the physically handicapped include those that cannot now be included because they do not qualify for these services because of the severity of their disability or their failure to meet the vocational requirements.

So a considerable amount of time, then, after that decision was made, was spent on problems that arise in how to implement this type of broadened program.

It was again unanimously agreed that some of the following problems would have to be approached directly and immediately in anticipation of any broadened program both in the field of what you might call the independent living program and also in expanded programs for the special education for the physically handicapped child.

The members of the workshop committee pointed out that the present limitations of medical and professional personnel in all specialties of special education and rehabilitation are in such short supply that current programs in both the public and voluntary fields are not meeting the present demands for service.

I might say, as an aside, that as a director of a voluntary nonprofit rehabilitation center I was concerned, and there were some 14 of our colleagues throughout the 4-State area who were at our hearings, or our workshop in Philadelphia who felt that same concern, that as these good people are referred to our doors we have obligations to our community to undertake their care and treatment.

While it was pointed out that inadequate budgets and rising costs are also a powerful limiting factor in presenting and rather meeting present needs, the manpower problem is fundamental to the improvement of the present services and for future expansion.

For example, here in our own State of New Jersey the vocational rehabilitation program is meeting but 1 of 6 cases requiring vocational rehabilitation services and there is a current estimated backlog of 62,000 men and women in our State, and an additional 7,800 who become physically disabled each year in our Garden State.

The Bureau of Census figures that is an ongoing survey since 1957 of the health status of our Nation, reports that one out of every seven Americans has a chronic or physical impairment, not counting the mentally ill.

Representatives of the 16 rehabilitation programs in both centers and hospitals reported, with respect to this shortage of personnel, vacancies in medical specialties, rehabilitation personnel, in nursing, occupational therapy, speech and hearing therapy, social service, physical therapy, psychological and rehabilitation counseling.

Our authorities reported similar deficiencies in staffing their needs in both instruction of students in colleges and universities and in providing both supervisory level teachers and teachers directly for the handicapped children and adults.

It is interesting that the directors of our schools of occupational and physical therapy give us the shocking news that not only are they not at full enrollment, but the supply of essential personnel in our work with the physically handicapped regardless of age, is actually less than it was 5 years ago.

The officials in the division of vocational rehabilitation in New Jersey and Pennsylvania reported acute shortages of rehabilitation counseling personnel both with respect to their present program and with respect to an anticipated increased load that would come through, shall we say, an expanded program in the independent living area.

Therefore, the workshop committee recommended that the Federal Government through the Department of Health, Education, and Welfare, and the appropriate departments in the Office of Vocational Rehabilitation undertake and provide funds for an intensive program of public education and publicity to recruit an adequate supply at all levels for medical, educational, and related professional specialties required for the staffing of special education and rehabilitation services for the physically handicapped.

I might say as an aside there was considerable discussion as to how we might seize upon something as dramatic as the problem as to what do you eat with your Thanksgiving turkey that would concern our American people and dramatize their concern with their health and if we could utilize as dramatic an incident as that with respect to the needs of personnel we might get the message to the far corners of the country.

Additional grants in aid are recommended to institutions providing training for this personnel and scholarship grants should be made available for both graduate and undergraduate levels of all specialties.

It was admitted in our discussions that both our voluntary and our present programs of Federal aid have been doing a great deal in this direction, but it was also pointed out that the scholarship aid did not reach down far enough in terms of those who wanted to enter for basic undergraduate training nor was it always available as readily as it could be for those who could not afford to drop out of employment and take full graduate training thus enriching both our instructional program at the university level and also providing more adequately for inservice training opportunities within our institutions and our service agencies.

A second consideration to accompany any expanded Federal support in special education and rehabilitation for the physically handicapped should be accompanied by a realistic appraisal of present services available, their effectiveness and a determination as to how these services might be expanded or modified to meet additional demands both as to staff, facilities, or as to budget.

A good number in the group expressed the concern that this type of planning should be on a regional basis.

Mr. ELLIOTT. Mr. Page, you have 1 hour minute.

Mr. PAGE. Thank you, sir.

In closing I would like to say that practically a whole morning was devoted to the manner in which our Federal agencies could undertake a more adequate implementation of presentation down to the local professional levels, including our medical staffs, those who are serving our patients, our handicapped children and adults directly, concerning past research, ongoing research, and certainly a more adequate interpretation as to what the Federal program now provides.

We found there were many people in the field that did not know how to use to the full that which the law now presently provides.

Thank you very much, Mr. Chairman.

Mr. ELLIOTT. Thank you very much, Mr. Page.

(The report referred to follows:)

EASTERN ATLANTIC REGIONAL WORKSHOP REPORT SUBMITTED BY WILLIAM K. PAGE

Cochairman:

Dr. L. Leon Reid, associate professor, speech education, University of Pittsburgh, Pittsburgh, Pa.

Mr. William K. Page, executive director, Kessler Institute for Rehabilitation, West Orange, N.J.

PRELIMINARY REPORT

General consideration

The Eastern Atlantic Regional Workshop Committee on Special Education and Rehabilitation conducted at Fels Institute, Philadelphia, on February 16 and 17, 1960, was attended by 66 participants representing both public and private programs of special education and rehabilitation for the physically handicapped and included representatives of all medical, educational, rehabilitation, and administrative authorities in the field of special education and rehabilitation in the States of New Jersey, Pennsylvania, Delaware, and Maryland. The Workshop Committee recommended that the Federal program for the rehabilitation of the physically handicapped include those who cannot now qualify because of the severity of their disability and their failure to meet the vocational requirement. It was unanimously agreed that any expansion of programs of special education and rehabilitation for the physically handicapped should be accompanied by plans and programs to meet the following problems:

Personnel shortage.—The members of the Workshop Committee pointed out that present limitations of medical and professional personnel in all the specialties of special education and rehabilitation were in such short supply that the current programs in both the public and the voluntary field were not meeting the present demand for service. While it was pointed out that inadequate budgets and rising costs are also a powerful limiting factor in meeting present needs, the manpower problem is fundamental to the improvement of present services and for any future expansion.

For example, the vocational rehabilitation program in the State of New Jersey is meeting but one in six cases requiring vocational services and there is a current estimated backlog of 62,000 men and women, and an additional 7,800 persons in New Jersey become disabled every week. Bureau of Census figures estimate that one out of every seven Americans has a chronic or physical impairment not counting the mentally ill.

Representatives of 16 rehabilitation programs in centers and hospitals reported vacancies in the medical specialties and rehabilitation personnel in nursing, occupational, physical, speech and hearing therapists, social service, psychological and rehabilitation counseling. Special educational authorities reported vacancies in teaching supervisors and training personnel. Directors of schools of occupational and physical therapy reported that their schools are not at full enrollment and the supply of this essential personnel is actually less than it was 5 years ago.

Officials in the divisions of vocational rehabilitation of New Jersey, Pennsylvania, and Maryland reported acute shortages of rehabilitation counseling personnel.

Recommendation

The workshop committee recommends that the Federal Government, through the Department of Health, Education, and Welfare and other appropriate departments undertake and provide funds for an intensive program of public education and publicity to recruit an adequate supply at all levels for the medical, educational, and related professional specialties required for the staffing of special educational and rehabilitation services for the physically handicapped.

Additional grants in aid are recommended to institutions providing the training of this personnel, and scholarship grants should be made available for both graduate and undergraduate levels for all the specialties.

The committee felt that the public program of rehabilitation was hampered by the emphasis on numbers as the criteria for measuring results and recommended that the Federal authorities give equal importance to quality of service and the severity of the disability group involved.

A second consideration to accompany any expanded Federal support of special education and rehabilitation for the physically handicapped should be accompanied by a realistic appraisal of present services available, their effectiveness and a determination as to how these services may be expanded or modified to meet additional demands, both as to staff, facility, and budget.

The workshop committee believed that present Federal legislation in this field was not being fully implemented at the local level through lack of understanding of its scope and application to specific problems serving the various disability groups. It recommended that the Department of Health, Education, and Welfare and other appropriate departments, intensify its program of information for those directing services to the handicapped at the state and community level to encourage a more effective use of what the law now provides.

The committee expressed concern that the existing disarticulation of programming and lack of coordination between public and private agencies would have to be corrected in order to meet the demands of those disabled not now served and certainly to undertake any expanded program in special education or rehabilitation.

It was felt that the present divisions of services provided by agencies serving the physically handicapped interfered with the normal continuity or "total life approach" to the problems of the severely disabled. The committee requests the attention of the appropriate authorities to the preschool and homebound handicapped child so that attention to the disability may be provided as early as possible. The workshop committee believes that Federal support must be given to the establishment and maintenance of diagnostic and evaluation services for all physically handicapped children and adults.

The committee further recommended the establishment of mobile diagnostic and evaluation teams where necessary for early case finding and for instituting appropriate treatment and training as soon as possible.

The committee felt that the results of important research and special studies in the field of special education and rehabilitation were not made available to the medical, educational, and rehabilitation authorities affording direct services in either the manner or degree where it could improve and affect the quality and direction of programs. Leadership on the part of the Department of Health, Education, and Welfare is requested in improving the dissemination of this important material to service agencies as well as to professional training institutions.

The committee was unanimous in its opinion that special education and rehabilitation services to the physically handicapped are a right and not a privilege.

The committee recommended an increase of Federal grants-in-aid for the establishment and the maintenance of sheltered workshops for the physically handicapped. It recommended an increase of Federal appropriation to the States for the purchase of direct services from voluntary institutions providing special education and rehabilitation. Voluntary rehabilitation agencies and institutions would benefit by increased Federal appropriations to the State agencies purchasing special education and rehabilitation services by enabling them to pay reimbursable costs and to make full utilization of the voluntary services for greater numbers of disabled individuals.

The committee recommended Federal subsidy of demonstration projects and the establishment of programs for the homebound.

While individual members of the Workshop Committee advocated compulsory health insurance through the social security system, there were others who felt the Government cannot and should not do the whole job. The opinion was expressed that the principle of Federal subsidy to stimulate community resources should be a continuing objective.

EASTERN ATLANTIC REGIONAL WORKSHOP—SPECIAL EDUCATION AND REHABILITATION STUDY, FELS INSTITUTE, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PA., FEBRUARY 16-17, 1960

Sponsored by U.S. House of Representatives, Committee on Education and Labor, Subcommittee on Special Education

SECTION REPORT—THE PHYSICALLY HANDICAPPED

Cochairmen:

Dr. L. Leon Reid, associate professor, Department of Special Education, University of Pittsburgh, Pittsburgh, Pa.

Mr. William K. Page, executive director, Kessler Institute for Rehabilitation, West Orange, N.J.

INTRODUCTION

The eastern Atlantic region, for the purposes of this special education and rehabilitation study, Committee on Education and Labor, U.S. House of Representatives, included only the States of Delaware, Maryland, New Jersey, and Pennsylvania. Dr. Reid and Mr. Page, cochairmen, section on the physically handicapped, invited 139 professional workers from these four States to participate in the section on the physically handicapped. On February 16-17, 1960, as a result of the official invitations, 66 professional individuals (6 from Delaware, 7 from Maryland, 14 from New Jersey, and 39 from Pennsylvania) were able to take time out from their important works to deliberate in this workshop. These 66 professional persons, because of their personal qualifications and longevity in the field, represented well the professions concerned with special education and rehabilitation in the eastern Atlantic region. The professional specialists in administration, education, medicine, physical therapy, occupational therapy, psychology, social work, from public and private agencies, were adequately represented.

For the purposes of this final report on the section on the physically handicapped, the deliberations have been divided under seven broad areas: Personnel training and recruitment, cost of medical care, cost of educational, social, psychological, and vocational rehabilitation, aid to new and/or existing programs, research, philosophy of special education and rehabilitation, and general. It must be pointed out that this workshop section considered special education and rehabilitation as overlapping and interrelated and for all practical purposes no division between the two were acknowledged.

PERSONNEL TRAINING AND RECRUITMENT

The lack of personnel in all areas of exceptionality, and in every specialty of each area was emphasized. The need for professionals to work with children and adults for each area of exceptionality is overwhelming. This need prevents the establishing of sufficient classes and programs. Also, on many occasions subtrained individuals are asked to fulfill positions for which they are not capable. Institutions training professionals in special education and rehabilitation are few and their number of graduates will never meet the existing demands. It is recommended that traineeships, fellowships, or scholarships be granted professionals in service and prospective professionals to assist in the cost of obtaining an adequate level of training from qualified institutions of learning.

A further emphasis was that, although the greatest demand is for trained professionals to work with children and adults in the schools, hospitals, clinics, and agencies, an additional need is paramount in the training institutions. The cost for the training of professionals to work with the physically handicapped is high, therefore, many qualified institutions, in order to train individuals, must receive supplementary financial assistance. It was agreed that grants must be made to training institutions for the initiating, developing, and carrying out the program of training.

In addition, training institutions need to be encouraged and aided in the training of professors in the various specialties concerned with special education and rehabilitation. The various professionals especially concerned are: teachers, psychologists, medical specialists, speech therapists, hearing therapists, re-

habilitation counselors, school administrators, rehabilitation center administrators, physical therapists, occupational therapists, nurses, prosthetists, hospital administrators, and recreation therapists.

COST OF MEDICAL CARE

It was fully agreed that the usual cost to an individual for medical care in the rehabilitation process is beyond equitable limits. Because of this, increased aid for medical care is needed. Provisions should be made to reimburse public and private agencies for medical care, including: physicians' fees, drugs, transportation, special surgery, hospital care, board and room, artificial aids and appliances, and the like.

COST OF EDUCATIONAL, PSYCHOLOGICAL, SOCIAL AND VOCATIONAL REHABILITATION

It was fully agreed that the usual cost to an individual for educational, psychological, social, and vocational rehabilitation in the rehabilitation process is too great for even the person with above average income. Increased aid should be provided for such services as: rehabilitation counseling, clinical psychology, job evaluation, job placement, job training, and other similar aspects of the rehabilitation process. It was fully agreed that an adequate job adjustment is the real objective of special education and rehabilitation. An adequate job adjustment should be defined as the type of work a disabled client can enter into whether in a factory, office, or at home (including what is termed independent living). (It must be emphasized that the rehabilitation process for a significant number of the physically handicapped begins shortly after birth. The preschool, school, sheltered workshop, counseling, training, placement, etc. are parts of the total rehabilitation process.)

AID TO NEW AND/OR EXISTING PROGRAMS

1. The importance of the sheltered workshop for the training and employment of the physically handicapped was urgently stressed. It is generally agreed that the Federal Government should provide increased support to the establishment and operation of prevocational, evaluative, terminal, and vocational training types of sheltered workshops. The importance of this type of facility at the junior high school level through adult vocational rehabilitation was emphasized.

The workshop group suggested other programs the Federal Government should generously support:

2. Programs for the education, training, and rehabilitation of the older adult (old-age group).

3. Federal support should be given to establishing independent living as a criteria for providing Federal-State services for the physically handicapped. This will remove the present limitation imposed by the requirement that a disabled person be able to return to gainful employment.

4. That the Federal Government organize and finance educational, psychological, social, and medical teams to identify, evaluate, and prescribe for the physically handicapped in key geographical areas where these diagnostic services are not presently available. The purpose would be not only to serve a diagnostic and evaluative function speeding services to the physically disabled, but would also provide a demonstration and a model as to how this important task should be done.

5. That the Federal Government support the programing and production of closed-channel television for training personnel in special education and rehabilitation.

6. That the Federal Government grant special support to existing private and public agencies in order that they may better meet the present demand for special education and rehabilitation services to the physically handicapped. This grant-in-aid should also anticipate the additional expenses involved in serving the vast numbers of individuals whose physical disability will fall within the independent living goal.

7. That the Federal Government sponsor and conduct a continuous nationwide program of public education and publicity for the recruitment of professional personnel required for staffing programs in special education and rehabilitation. It was emphasized that throughout the four-State area, acute shortages of professional staff placed severe limitations on meeting present needs.

RESEARCH

It was pointed out that a great amount of knowledge is available in special education and rehabilitation to date; however, the proper coordination of modern research information to professionals is inadequate. It was suggested that the Federal Government somehow devise a system for the articulation and coding of research information so that those concerned can have easy access to Federal, State, private, and individual research contributions in special education and rehabilitation.

Mandatory, of course, are more efforts in research if special education and rehabilitation are to advance significantly. Some of the types of research suggested are:

1. Investigations into the theory of learning with exceptional individuals.
2. Job analysis studies for the handicapped.
3. Investigations into the aspects of interprofessional cooperation.
4. More medical research.

PHILOSOPHY

In all provisions for the physically handicapped, the Congress and agencies concerned should be reminded that special education and rehabilitation are rights of the individual that should be provided from the moment of the identification of the disabling condition through total rehabilitation.

GENERAL

The following are some general comments and recommendations, with complete agreement by this workshop group, that have essential bearing in the provisions for the physically handicapped.

1. Liberalize the Federal laws and provisions for the physically handicapped.
2. Encourage at all levels the participation of both public and private agencies in jointly planning for and cooperating in programs for research with respect to the physically handicapped.
3. Reevaluate the present policy that OVR cannot consider a client active until 16 years of age. This workshop recommended that no age limit be requested as certainly a large number of individuals should become clients of OVR long before 16 years of age.
4. More support for demonstration and experimental projects in the field of special education and rehabilitation for the physically handicapped. The philosophy which requires a guaranteed result in the field of health and welfare service for the disabled is, in many cases, unduly restrictive. It was recommended that the Federal governmental agencies acknowledge calculated risk involved in supporting a purposeful research and demonstration project.
5. Reduce red tape.
6. Eliminate current tax restrictions with respect to sheltered workshops for the physically handicapped.
7. Allow for income tax deductions for the physically handicapped.
8. The members of the workshop group were of the opinion that there are many barriers to the prompt and efficient service to the physically handicapped resulting from dislocation of services and outworn agency policies with respect to age and disability served. This problem restricts the development of sound interprofessional and interagency communication and coordination of services. It was further agreed that this is, in the main, a local problem. However, leadership and the development by the appropriate Federal agencies of more simplified lines of communication and programs of regional planning involving all agencies and groups concerned, would encourage a solution of local problems. It was further recommended that the Federal Government evaluate its present methods and policies with respect to the handling of funds, systems of communication, and designation of areas of responsibility, with the purpose of eliminating artificial but nonetheless real barriers to efficient and adequate services to the physically handicapped.
9. It was further recommended that the appropriate Federal authorities responsible for the evaluation of public programs for the disabled give equal emphasis to the quality and the severity of the disability group served as well as to the number of cases closed.
10. It was further recommended that the Federal Government encourage the elimination of architectural barriers which prevent the physically handicapped from having normal access to places of employment, public buildings, recrea-

tional facilities, etc. It was further suggested that Federal grants for the construction of any facilities should require design features suitable for the employment and access of the physically handicapped.

Respectfully submitted by the cochairman.

L. LEON REID, PH. D.

*Associate Professor, Department of Special Education,
University of Pittsburgh, Pittsburgh, Pa.*

WILLIAM K. PAGE, M.A.,

*Executive Director, Kessler Institute for Rehabilitation,
West Orange, N.J.*

MR. ELLIOTT. Our next witness comes to us from the section of the workshop, the socially and emotionally maladjusted.

That report will be given by Dr. Elizabeth Kelly, assistant superintendent in charge of special services, 31 Green Street, Newark, N.J.

STATEMENT OF DR. ELIZABETH KELLY, ASSISTANT SUPERINTENDENT IN CHARGE OF SPECIAL SERVICES

DR. KELLY. Mr. Elliott, and members of the subcommittee on Education and Labor of the U.S. House of Representatives, the section on which I am reporting is entitled the socially and emotionally maladjusted.

On February 17, 1960, a workshop group consisting of three psychiatrists, three educators, two educators who are also diplomats in clinical psychology, and three from the field of rehabilitation, one a professor of education at a metropolitan university, met at Fels Institute, Philadelphia, Pa., and considered the unmet needs of children and adults who are or should be classified as socially and emotionally maladjusted.

Five areas of study were agreed upon unanimously by the committee for serious consideration. They were identification, including diagnosis and evaluation, prevention planning, including management, therapy, guidance and counseling, personnel training, research, and sociological understanding.

In this latter phase we felt we were introducing an important part of the consideration for this committee to be related to this subcommittee.

In summary, the findings of this committee concentrated on three different aspects for reporting here today.

The incidence of the socially and emotionally maladjusted from the school point of view, the definition of social and emotional maladjustment, and then the recommendations to this committee on the unmet needs in this particular field.

The incidence, a significant number of emotionally and socially maladjusted children and adults are in need of assistance and reeducation.

It has been reported that there are as many as 1.5 percent of children of school age who are in immediate need of varying kinds of treatment and this total number might amount to 645,000 children between 5 and 17 years of age throughout this country who need this help and assistance.

As to the definition of the socially and emotionally maladjusted, no final definition of social and emotional adjustment was agreed upon.

Operationally, the participants characterized the group under consideration as displaying consistent disturbance of affect, intellection,

and behavior under environmental circumstances which did not appear to be traumatic to individuals or groups widely considered as average.

It was understood that maladjustment in this context did not imply mental deficiency.

For the child, the disturbance of adjustment was considered to be of sufficient severity to preclude his continuing in an unspecialized educational setting.

For the adolescent and adult maladjustment implied significant defects in economic competence and in intra and interpersonal relationships.

This group was further characterized as excluding those whose handicap was of such severity as to require institutionalization, either correctional or psychiatric.

The recommendations of this committee in summary are as follows:

Federal support of grants-in-aid to assist local communities to overcome the devastating effects of these conditions have been recommended by this committee.

Specifically they are, first, support of outpatient clinics and residential facilities to allow for the development of new facilities where necessary and for the expansion of services in existing installations to provide diagnosis for this group of socially and emotionally maladjusted.

Second, inservice and preservice training for all personnel customarily engaged in these programs for children and adults as school administrators, teachers, psychologists, social workers, therapists, nurses, public health and school nurses, school physicians, and rehabilitation workers.

The third involved research such as programing as to demonstration projects involving methods of school grouping, staff requirements, individual service group methods of management, support of counseling for older clients.

The second aspect of research involved basic research to determine causes and prevention of emotional and social maladjustment.

The third aspect of this research, the recommendation was expansion of sheltered workshops under OVR for this disability group.

Mr. Elliott, we felt our second recommendation here that your bill 494 might well fit into this situation in regard to this inservice and preservice training for all this type of personnel if this bill were expanded.

Also, your bill 3465, this matter of basic research might well fit into this area, also.

This summary report is respectfully submitted by the committee on the socially and emotionally maladjusted.

Mr. ELLIOTT. Thank you very much, Dr. Kelly.

(The statement and report referred to follow:)

STATEMENT OF DR. ELIZABETH M. KELLY, ASSISTANT SUPERINTENDENT OF SPECIAL SERVICES, NEWARK BOARD OF EDUCATION, NEWARK, N.J.

Mr. Elliott and members of the Subcommittee on Education and Labor of the U.S. House of Representatives studying the unmet needs of special education and rehabilitation in the United States, the testimony which I am presenting is on behalf of all programs in special education in this country and is representative of my own thinking and convictions as one of the veteran educators in this field of work.

There are two aspects of this program in special education which require serious consideration and assistance. One has to do with the public relations aspects and involves the attitudes of lay and professional people, generally, toward the educational rights and needs of the exceptional, specifically the handicapped. My reference here is to school-age children, particularly. Yet, I do not for 1 minute wish to minimize the struggles of the adult handicapped to realize a life of dignity and security through independent living. My experiences and my responsibilities for many years have been for the most part with children. Therefore, I am speaking of the field which I know best.

The handicapped, or the gifted, for that matter, should not have to wait upon appeals to the generosity of men in order to obtain needed funds to sustain minimum educational programs for those of these groups. Neither should the Congress have to be galvanized into action by potent forces to effect enabling legislation to motivate educational programs for the gifted as well as the handicapped.

Through the direct efforts of the Congress, funds should be made available to each chief State school officer for the establishment of a bureau of the handicapped in each State to determine the unmet needs of those who are exceptional or handicapped. The responsibility of this bureau would be to survey these unmet needs through a program of valid research; to publish these findings; and to promote an understanding of them among the citizens of each State. Another responsibility for this bureau would be the guidance of necessary citizen action in recognition of the unmet needs of the handicapped. As the needs of the handicapped are tabulated by communities and regional areas of each State, the impact of these needs and the steps necessary to meet them in terms of new school construction, adequate staff, educational equipment and materials, and transportation should become the concern of citizens as well as educators to implement through cooperative planning. Proper physical accommodations for the education and training of the handicapped, from childhood through young adulthood, are as important, if not doubly so, as that planned for the average boy and girl. Funds for general school construction allotted by Congress should have a stipulated amount earmarked for programs wherever needed in special education. A third responsibility of this designated bureau would be to cooperate with the State rehabilitation commission on a coordinating team basis to chart a proper program for those handicapped who are identified early in life as requiring a special type of educational planning to insure economic and social competency in adulthood.

The second aspect of special education in which there are serious deficiencies is in the field of teacher training. Too few teachers are being trained for the program of special education. The lack of trained teachers in the areas of the mentally retarded, the physically handicapped, including those with orthopedic defects, the cerebral palsy, blind, partially sighted, deaf, hard of hearing, and the emotionally and socially maladjusted, is impeding the proper guidance and training of the handicapped. Listed with the aforementioned handicaps should be, the blind with deafness, the blind with cerebral palsy, and those with brain damage. These three additional handicaps receive little or no consideration in teacher training institutions since the educational approach to them is perplexing and difficult. Basic research is necessary to make known to those who undertake the teaching of children with double handicaps, as well as the teachers of these teachers, the necessary educational techniques and methods to be adapted in the guidance of those who present dual problems in learning and behavior.

To offer complete training and preparation in teacher training institutions, opportunity should be offered to trainees as well as to those in service, such as administrators, supervisors, teachers, therapists, school psychologists, school social workers, rehabilitation workers, school nurses, and school physicians, for a program of orientation in the understanding and management of various types of handicapped children.

Mr. Elliott and members of the Subcommittee on Education and Labor, I am making a plea for Federal Government support to State and local communities of sufficient incentive funds so that adequate programs of special education and rehabilitation may be effective in ameliorating the conditions which now exist as to inadequate facilities and programs for the handicapped and too few teachers trained to teach them.

In order to develop and organize proper programs for the handicapped and to interest teachers to prepare and to teach in the field of special education, definite assistance from Congress, through grants-in-aid, must be made available to

realize the objectives of this program. In summary, these objectives are as follows:

1. A broad administrative program of basic research pointed toward the identification of the various types of handicaps.

2. Administrative action to implement programs for the training of handicapped children from childhood through young adulthood, including new school construction, if necessary.

3. Teacher training programs developed on a wide front to include opportunity for clinical observation of various types of handicapped and the procedures used in the diagnosis and classification of those in this group.

4. Cooperative planning which would blend efforts of the Division of the Exceptional in the U.S. Department of Health, Education, and Welfare with departments of special education on State and local levels; and with approved teacher training centers in the development of preservice and inservice programs, pilot studies and demonstrations, summer workshops, and national and regional conferences.

5. Development of a Bureau for the Handicapped in each State as a clearing house for all the foregoing activities and for the dissemination of necessary information to the public and the educational profession as a whole and to the supervisors and teachers in special education in particular.

It is my judgment that the resolution introduced by Mr. Elliot (H.J. Res. 494) should be expanded to include: (1) all teachers of all areas of the handicapped with the express provision that it will be the prerogative of the U.S. Commissioner of Education to appoint members of an advisory committee to assist him in screening worthy applicants for aid under this law; (2) that all such programs should be carried out within the structure of each State Department of Education; and (3) that the Division of the Exceptional of the U.S. Office of Education of the Department of Health, Education, and Welfare, should be the Federal agency through which funds for teacher training should be approved.

SPECIAL EDUCATION AND REHABILITATION STUDY, SUBCOMMITTEE ON EDUCATION
AND LABOR, U.S. HOUSE OF REPRESENTATIVES

SECTION ON THE SOCIALLY AND EMOTIONALLY MALADJUSTED

Committee:

Anthony S. DeSimone
Ruth P. Eason
Merrill T. Hollinshead, Ph. D.
Harry S. Howard, M.D.

Abraham Jacobs, Ph. D.
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Cochairmen:

Elizabeth M. Kelly, Ph. D.
Paul Hann, M.D.

Fels Institute, University of Pennsylvania, Philadelphia, Pa., February 16, and
17, 1960

INTRODUCTION

The committee which had the responsibility of developing a report on the unmet needs of the socially and emotionally maladjusted discussed the problem quite thoroughly. The individual ideas and judgments of each member were projected and exchanged. The merits of each point of view were carefully weighed and sharpened until those ideas which were most acceptable met the test of every member's thinking.

The incidence of maladjustment, socially and emotionally, reported as being 1.5 percent of children of school age, was the pivot on which a program for this group was developed by the committee. The aspects of the problem deemed important to the solution of this problem before the committee involved the following:

1. The identification of the emotionally and socially maladjusted.
2. Prevention planning for this group, adults as well as children.
3. Social understandings of some of the factors causing emotional and social maladjustment.
4. Training of personnel for management of the emotionally and socially maladjusted.

5. Research needed to plan clear-cut steps for the amelioration of this problem.

The discussion of each phase is given forthwith. Subcommittees of the committee as a whole worked on the different phases and blended their findings and on the basis of them offered recommendations for implementing them.

This report is unanimous and represents the best thinking at this time of the committee.

THE IDENTIFICATION OF THE EMOTIONALLY AND SOCIALLY HANDICAPPED

The principal case-finding agents involved in the identification of emotionally and socially disturbed persons are not necessarily the same for all age groups, although in the process the family and the medical practitioner will be important at all ages. Thus, there is need for education of the public regarding the range of normal behavior and its limits, in order that family members—and this includes most of the public—may better carry their case-finding responsibilities.

In preschool ages, instrumentalities with the best opportunity to find cases will be the general medical practitioner and the health department, through its maternal health and keep-well services. Programs are necessary to raise the sensitivity of the professionals in these areas so that this responsibility may be efficiently discharged.

All children are required to attend school unless it is determined after due consideration that exclusion is necessary. All are subjected to this screening experience and are functionally tested in it, often over a period of years. Thus, the teacher must be able to identify children who are unable to adapt to the school experience, or perhaps more importantly, those who will be hurt by exposure to pressures inherent in the school.

With adults, the working situation offers many opportunities for identification of the emotionally disturbed although other institutions such as higher educational centers, churches, social and welfare agencies also have opportunities. Social workers, ministers, educators, and personnel counsellors will be able to increase their case-finding skill through appropriate educational programs.

One group of the maladjusted presenting great and largely unrealized rehabilitation potential offers no identification problem. This is the group of patients discharged from psychiatric hospitals.

Identification or casefinding must distinguish between the disturbed or ill individual as against the temporarily upset person the mischievous child and the eccentric adult. For illness as for social disturbance, it must discriminate between the more and the less serious. These are delicate judgments. The margin of safety lies in overidentification. Diagnostic facilities are still far from sufficient. For the near future probably only the more serious problems can be referred for further study.

The diagnostic procedure follows identification. It will include study along many parameters: Psychiatric, medical, psychologic, and sociologic; and in many areas of possible stress: Home, school, work, and leisure time. Such a study must include an evaluation of etiologic factors, including brain or other organic damage or disease and psychologic and social stresses.

Diagnostic study should culminate in practical recommendations for the management of those with static conditions, with the aim that behavior approach the "normal" so far as the condition will allow, and that adjustment be optimal within individual capacities. Many cases in which psychologic or social stress is primary offer a hopeful prognosis. Here relief may be achieved through psychotherapy usually involving the individual as well as his family. Social stress may be relieved through techniques of environmental manipulation available in the community or by adjustment of the educational situation, including the teacher's understanding and attitude.

Improvement in the identification of cases involves increased knowledge and sensitivity of the public, and of certain professional persons such as medical practitioners, teachers, public health personnel, clergymen, personnel counsellors in industry, and others. Diagnostic facilities which take into consideration organic, psychologic, and social pathology should be available and used to design adjustment and treatment procedures.

PREVENTION PLANNING

Prevention planning begins with an awareness of the need for an extensive diagnostic evaluative procedure that includes physical, psychological and psychiatric examinations plus a period of observation of the current functioning of the

individual in the family, school, social, or vocational settings to determine the educational and rehabilitation services required.

Prevention planning is assisting the family—

(a) to recognize the need for early treatment;

(b) to take full advantage of every resource in the community for service to the individual and the family such as those offered by mental hygiene clinics, marriage counseling, family service agencies, parent study classes, vocational rehabilitation agencies, parent-teacher study committees.

The responsibility of the school in prevention planning is to—

(a) detect early symptoms of maladjustment;

(b) develop programs for children such as special classes, counseling and guidance, work-study programs;

(c) motivate within the school staff a climate promoting good mental health.

Coordination of community services and resources is necessary for a total integrated approach to assist the individual to achieve his maximum functional level in society. Such community services would be those extended by health and welfare agencies, vocational rehabilitation, courts, church, and recreational facilities.

The need to develop an adequate number of trained personnel is a basic assumption underlying the services described as essential in prevention planning.

MANAGEMENT

Resources described in the prevention program have a responsibility also for management and treatment. This early prevention and treatment reduce more serious emotional or social maladjustment in later life. Coordinated educational and rehabilitation activities should be started as soon as symptoms are detected.

SOCIAL UNDERSTANDINGS

In drafting Federal legislation related to the needs of the socially and emotionally handicapped, the principle of local community involvement in all aspects of the recommended program should be scrupulously observed. This appears to be of particular importance in the areas of planning and of financing.

Recognition needs to be given to the marked cultural and socioeconomic variations present in the majority of our communities. These differences, the most significant of which may be covert, readily produce misunderstandings, tensions, and maladaptations among children as well as adults. Service programs oriented to the needs of the socially and emotionally handicapped must have sufficient intrinsic flexibility to insure recognition of these variations. In training programs of whatever nature, emphasis should be laid on the conscious recognition of these variations and on the need to take into account the value system and cultural level of individuals and groups being served.

Examples of these differences producing conflicting attitudes among socioeconomic variations may be observed between children and adults of various cultures toward children and adults of an accepted culture; and between a community with a traditionally accepted culture toward families and groups of various cultures. These attitudes are manifested not only among children and adults on neighborhood levels but also among individuals of larger spheres of activities in schools, churches, in business, civic, labor, and political activities.

Interactions of individuals and groups reflecting such opposing attitudes provide friction and a multitude of social reactions such as ostracism and rejection, creation of more than one class of citizens, ridicule and contempt, hostility and aggression, and erection of barriers to all modes of communications.

Since identification with the exemplars of prized cultural values is a significant element in all education, continuing attention should be given to the task of making explicit the broad system of ethical beliefs and traditional fidelities which actuate the majority of responsible citizens of the United States.

PERSONNEL TRAINING

The group designated as usually having the responsibility for socially and emotionally maladjusted children and adults consists of:

Teacher	School and public health nurse
Guidance counselor	Administrators
School psychologist	Supervisors
School social worker	

Those of this group needing specialized training in the scope of this training for selected professional personnel are as follows:

Teacher:

- Recognition of symptoms of emotional and social maladjustment.
- Referral to proper agency.
- "First aid" in a classroom situation.
- University training in basic courses for proper orientation.
- Clinical teacher experience or internship:
 - With individuals.
 - With groups.

Guidance counselor:

- University training in basic orientation of problem.
- Recognition of symptoms.
- Referral to proper agency.
- Recognition of interrelated roles of educational and rehabilitation counselors.

School social workers:

- Training in and/or experience in field of education, generally, and of exceptional children in particular.
- Psychiatric orientation on an internship basis.

School psychologist:

- Clinically trained and with sufficient knowledge of and experience in educational programing and learning problems to make meaningful recommendations to teachers and administrators.

Preservice training

Proper coursts offered to provide clinical experience on college and university levels for undergraduates.

- Coordination with local schools for practice on an undergraduate level.
- Federal grants-in-aid for scholarship on an undergraduate level.

Inservice training

Proper courses offered to provide advanced clinical experience on a university level.

Coordination with local schools for practicums on a graduate level for experienced professional personnel in supervisory and administrative roles and for those teachers studying for leadership in this program.

- Federal grants-in-aid for fellowship stipends for:

Administrators

Supervisors

Teachers

School psychologists

School social workers

School counselors

School nurses

Marriage and family counselors

Clergymen

Rehabilitation workers

RESEARCH

A considerable body of knowledge is available in connection with the management, care, and treatment of emotionally disturbed and socially maladjusted children and adults within the setting of a residential institution. However, when we concern ourselves with the many children and adults, still maintained in the community, whose personality problems obstruct their school learning and their later life adjustment, our goals are less well defined and we are less sure of our techniques. Thus there is an urgent need for research which will provide for us a basis for setting up effective methods of special education and rehabilitation for this disability group. The following research emphases could profitably be facilitated by cooperative endeavors involving Federal, State, and local resources; the primary responsibility for the recognition of these problems and the impetus for finding solutions should be spelled out in Federal legislation.

1. Research on nomenclature, classification, and incidence

- (a) What are the most appropriate diagnostic categories?
- (b) How extensive is the problem?

2. Research organized around demonstration projects

- (a) What are the most appropriate ways of grouping the ED (emotionally disturbed) and SM (socially maladjusted) within the public school setting?

- (b) What are the optional staff requirements for group programs?
- (c) Which ED's and SM's can be maintained within regular groups, with supporting roles being furnished by what kinds of disciplines?
- (d) What techniques of counseling and support should be used with these clients?

3. *Research in prevention*

- (a) With early identification, can we prevent the development of unfavorable personality organization, and if so, by what means?
- (b) Is there a need for aggressive casework techniques for some clients?
- (c) What are the essentials of total counseling? (Planning a program of prevention, evaluation of the role of clinic, school, social agencies, religious organizations, authoritarian resources, etc. Use of the "team" concept involving several of these resources.)

4. *Basic research*

Research on etiology; importance of organic versus psychogenic factors; relating specific direction of treatment to etiological groupings, etc.

RECOMMENDATIONS

Federal support of grants in aid to assist local communities to overcome the devastating effects of these conditions has been recommended by this committee. Specifically, they are:

1. Support of out-patient clinics and residential facilities to allow for the development of new facilities where necessary and for the expansion of services in existing installations to provide diagnosis for this group of socially and emotionally maladjusted.

2. Inservice and preservice training for all personnel customarily engaged in these programs for children and adults as: school administrators, teachers, psychologists, social workers, therapists, nurses (public health and school) and school physicians and rehabilitation workers.

3. *Research:*

- (a) Programing as to demonstration projects involving—
 - (1) Methods of school grouping.
 - (2) Staff requirements.
 - (3) Individual versus group methods of management.
 - (4) Supportive counseling for older clients.
- (b) Basic research to determine causes and prevention of emotional and social maladjustment.
- (c) Expansion of sheltered workshops for this disability group.

WORKSHOP REPORT ON THE SOCIALLY AND EMOTIONALLY MALADJUSTED

On February 16 and 17, 1960, a workshop group consisting of three psychiatrists, three educators, two educators who are also diplomates in clinical psychology, and three from the field of rehabilitation, one a professor of education at a metropolitan university, met at Fels Institute, Philadelphia, Pa., and considered the unmet needs of children and adults who are or should be classified as socially and emotionally maladjusted. Five areas of study were agreed upon, unanimously, by the committee for serious consideration. They were: identification, including diagnosis and evaluation; prevention planning, including management, therapy, guidance, and counseling; personnel training; research; and sociological understandings.

In summary, the findings of this committee consisted of the following:

Incidence

A significant number of emotionally and socially maladjusted children and adults are in need of assistance and reeducation. It has been reported that there are as many as 1.5 percent children of school age who are in need of varying kinds of treatment.

Definition

No final definition of social and emotional maladjustment was agreed upon. Operationally, the participants characterized the group under consideration as displaying consistent disturbances of affect, intellection and behavior under en-

vironmental circumstances which did not appear to be traumatic to individuals or groups widely considered as average. It was understood that maladjustment in this context did not imply mental deficiency. For the child, the disturbance of adjustment was considered to be of sufficient severity to preclude his continuing in an unspecialized educational setting. For the adolescent and adult, the maladjustment implied significant defects in economic competence and in intra- and inter-personal relationships. This group was further characterized as excluding those individuals whose handicap was of such severity as to require institutionalization, either correctional or psychiatric.

Recommendations

Federal support of grants-in-aid to assist local communities to overcome the devastating effects of these conditions have been recommended by this committee. Specifically, they are:

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3. Research:

(a) Programing as to demonstration projects involving—

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- (3) Individual versus group methods of management.
- (4) Supportive counseling for older clients.

(b) Basic research to determine causes and prevention of emotional and social maladjustment.

(c) Expansion of sheltered workshops for this disability group.

COMMITTEE

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Cochairmen: Elizabeth M. Kelly, Ph. D., and Paul Hanft, M.D.

Mr. ELLIOTT. Our next witness who comes to us from the speech handicapped section of the Philadelphia workshop is Vaughn Weber, speech therapist, Board of Public Education, Pittsburgh.

STATEMENT OF VAUGHN WEBER, SPEECH THERAPIST, BOARD OF PUBLIC EDUCATION, PITTSBURGH

Mr. WEBER. Mr. Chairman, members of the Subcommittee on Special Education, the speech handicapped section of the Eastern Atlantic Regional Workshop was attended by 25 professional individuals representing 7 types of programs in the areas concerned.

Participants were affiliated with colleges and universities, public school therapy, State departments of government, dealing with speech handicapped, bureaus of vocational rehabilitation, hospitals, resident training programs, and community centers.

Each workshop member enjoyed the stimulating challenge of evaluating our profession, our standards, our needs, and our goals.

From the workshop, a formal report has developed and will be submitted to you within 10 days. Perhaps today, you will be interested in selected highlights of our section.

I will stand the risk of oversimplification to ease your listening task by grouping the highlights of our needs under three words. These words are personnel, programs, and publicity.

A. In considering our first word, "Personnel," we are focusing on the basic need in our professional area.

An estimation has been made recently that over 6 million U.S. citizens have handicapping speech problems. Our estimation of incidence in the 4-State area of Delaware, Maryland, New Jersey, and Pennsylvania, is that 705,100 citizens of all ages have handicapping speech problems.

In the public schools of our workshop region, we have only 520 speech therapists. We need an additional 1,056 speech therapists to service the schools alone.

We need additional personnel, prepared at the highest level of professional competence to provide effective early diagnosis, appropriate therapy, and/or prevention of speech disorders in all age groups.

We need to stimulate young people to enter the profession of speech pathology.

At the present time, only 400 persons each year are being prepared for our profession.

Our needs indicate that at least 1,500 professionally trained persons should be graduating from training institutions.

We need to share the training and experience of our professional speech pathologists through their consultation with and advice to interested groups in related areas, government, and society.

B. Let us consider now the second word I previously mentioned, "Programs." The highlights of our needs in this category may interest you.

We need to implement a program for effective early diagnosis and/or prevention of speech disorders.

In addition to the personnel required for the program's development, we need an educational program instituted for persons in related professions to help them develop an acute awareness of the handicapping effects of speech problems, and to point up the necessity of referring persons of all ages with such problems to competent professional speech pathologists.

An educational program directed toward the general public will enable them to recognize the importance of early recognition, diagnosis, and therapy for persons in all age groups.

We need to maintain and upgrade the standards of our existing training programs. New training centers must be developed to prepare the needed professional speech pathologists. We need to maintain as minimum requirements the certification standards, established by the professional organization in the area of speech pathology.

We need to maintain a recognized standard of therapist-to-patient ratio.

In the public schools, 1 therapist to 100 individuals is an accepted ratio. Among the general population, 1 speech pathologist to 50,000 persons is an accepted ratio.

We need to coordinate local services more effectively, speech therapy programs, with related programs.

We need to develop a comprehensive catalog to include the wide range of service facilities, nationwide in scope, and periodically updated.

We need to provide adequate therapy programs for all adult persons to aid their social adjustment and ease of communication.

We need to expand and improve existing facilities through maintaining standards of physical plants and equipment.

We need to develop additional facilities to meet more adequately the needs of our speech handicapped citizens.

We need to further develop our programs of research, maintaining the highest standards of professional competency, in programs which are recognized as meeting the standards of our professional association.

C. Finally, let us briefly consider the third group of needs under the heading "Publicity."

We need to inform the public about our profession of speech pathology, our services to all age groups, and our relations to other rehabilitative areas.

We need to inform the related professions about speech pathology, our speech pathology, our services to all age groups, and our role in relation to other professions.

We need to inform the public and related professionals of the vital importance of early recognition, diagnosis, and therapy to speech handicapped individuals in all age groups.

Publicity, programs, and personnel, three words to categorize our needs as a profession.

We in the profession of speech pathology, are working toward meeting those needs.

In our formal report which you will receive, you will be interested in how far we in the profession have progressed. We hope you will consider our needs and our recommendations concerning them detailed in our report.

We further hope you will weave your considerations into the appropriate legislation to aid us in meeting our needs so that we may more effectively help the speech handicapped of our eastern Atlantic region.

Thank you.

Mr. ELLIOTT. Thank you very much, Mr. Weber, for your testimony.

Mr. WEBER. You are welcome.

WORKSHOP REPORT ON THE SPEECH HANDICAPPED

The workshop section on the speech handicapped was attended by 25 professional individuals from the States of Delaware, Maryland, New Jersey, and Pennsylvania. These individuals gave freely of their time and participated in serious and meaningful deliberations. They represented a total of seven different types of programs concerned with the speech handicapped. Participating were individuals from colleges and universities, bureaus of vocational rehabilitation, public school speech programs, State departments dealing with the speech handicapped, hospitals, and resident training institutions.

The great need of speech handicapped individuals in the United States for rehabilitation services has been well documented on a national basis. Recently, it has been estimated that over 6 million U.S. citizens of all ages have handicapping speech problems, and in addition, more than 2 million have handicapping hearing problems. It has been estimated that during the next 10 years at least 20,000 additional professionally trained personnel will be needed to give proper help to these people.

In the eastern Atlantic four-State area (Delaware, Maryland, New Jersey, and Pennsylvania), there are approximately 20,718,000 citizens; of this group, 705,092

are believed to have handicapping speech problems. The accompanying table indicates the extent of the problem for each of the States of interest.

TABLE I.—*Estimated extent of handicapping speech disorders among all ages in the eastern Atlantic region (based on estimated 1959 population)*

State	Total population	Total with speech problems
Delaware.....	434,000	15,436
Maryland.....	3,031,000	103,054
New Jersey.....	5,930,000	201,620
Pennsylvania.....	11,323,000	384,982

The major deliberations of this workshop group on the speech handicapped were concerned with several areas to be considered when plans are made to habilitate the speech and hearing handicapped. The statements which follow will be oriented toward a brief statement of each of the needs and recommendations developed by the workshop group regarding courses of action relative to each need.

I. EARLY DIAGNOSIS AND/OR PREVENTION

Prevention of speech disorders implies early recognition and comprehensive and differential diagnosis. This is essential because:

A. Early recognition and diagnosis, followed by appropriate therapy, prevent speech problems from developing into more severe disorders.

B. Early recognition and diagnosis, together with appropriate therapy, prevent the numerous emotional, social, vocational, and educational problems commonly developed as concomitants to uncorrected speech problems.

C. Early recognition and diagnosis make possible the beginning of appropriate therapy when the problem is at a relatively minor stage and presents the greatest possibility of being corrected. Ordinarily, later therapy requires a much greater expenditure of funds, time, and effort to obtain a given therapeutic benefit than does therapy at the early stages.

In order to implement a program for effective early diagnosis and/or prevention of speech disorders, the following procedures are recommended:

A. Additional personnel prepared at the highest levels of professional competence are needed to carry out the appropriate activities.

B. An educational program should be instituted for persons in other professions related to speech pathology (e.g., medicine, psychology, teaching, school administration, social casework) for the purpose of developing an acute awareness of the great handicapping effects of speech problems and for the necessity of referring persons of all ages with such problems to competent professional speech pathologists.

C. An educational program directed toward the general public to enable them to recognize the importance of early recognition and diagnosis of speech problems, and to utilize services of the speech pathologist.

Although early diagnosis and recognition may be thought of as applying primarily to children, the same principles should be applied to adults who acquire speech problems. Among the more serious problems of this type are those which result from laryngectomy, cardiovascular accidents, traumatic injuries, effects of polio and multiple sclerosis.

II. RECRUITMENT AND TRAINING OF SPEECH PERSONNEL

In order to carry out the early recognition, and diagnosis, and to provide therapy for persons of all ages, there is a pressing need now for more personnel. At the present time approximately only 400 persons are being trained each year in this country in speech pathology. Indications are that the rate should be at least 1,500 professionally trained persons per year graduating from training institutions if the Nation is to be provided with the professional personnel needed within the next 10 years. Table 2 indicates the immediate need for speech specialists in the public schools of the eastern Atlantic region.

TABLE 2.—*Estimated immediate need for speech specialist in the public schools of the eastern Atlantic region*

State	Total required	Total now available	Additional needed
Delaware.....	26	11	15
Maryland.....	300	100	200
New Jersey.....	1 500	1 59	1 441
Pennsylvania.....	750	2 15	400

¹ Full time.² Part time only.

In order to stimulate young people to enter the field of speech pathology as a profession the necessary professional training must be made available to them. An effective method of recruiting student speech pathologists is to institute a large-scale program of financial aid to such students. Although competence in speech pathology requires graduate level training leading to advanced academic degrees, effective recruitment should begin at the undergraduate level. In other words, financial aid in the form of scholarships and/or fellowships should be made available at both graduate and undergraduate levels. In the four-State area considered by this workshop, an estimated 1,056 additional speech therapists are needed in public schools alone. Although the cost of academic training varies markedly from institution to institution, it is estimated that the usual costs are between \$2,000 and \$3,000 per year for the academic training of students in the field of speech pathology. (This estimate is the cost to the students, and does not necessarily include support for the training program granted by the State governments to universities and colleges or by foundations supporting private training institutions.)

The workshop committee recommends that a scholarship or fellowship program be instituted which considers the above estimate as the magnitude of financial aid to competent students, and should be on a graduated scale related to level of academic training.

A further technique in the area of recruitment, which is believed to be effective and is hereby recommended by the workshop group, is that of wide scale publicity of the field of speech pathology, recognition by all departments of government of speech pathology as a profession, and description of the profession of speech pathology in official publications, manuals, etc.

A concomitant to stimulating and facilitating students to embark on a program of professional preparation in speech pathology is the need to assist professional educational programs which provide the appropriate education to these student speech pathologists. Specifically, the workshop group recommends that a program of grants directly to academic institutions for the purpose of completing, upgrading, or enriching their programs of study be carried on.

In the past a number of Federal departments and agencies have carried on, and are still carrying on, programs of grants to assist research, and fellowships in the field of speech pathology. Although the workshop committee does not at this writing see a specific problem in the manner in which the research and other funds have been dispersed in the past, it is recommended that financial assistance be directed only toward capable students and be of assistance to training institutions which either in the past have demonstrated a high-quality program or which can be upgraded to meet recognized standards of academic and professional training, and research.

III. STANDARDS OF CERTIFICATION

At this writing there is a diversity of standards for certification in schools and diversity of standards of recognition for persons trained in the field of speech pathology. Any Federal legislation in the area of speech pathology should include guarantees that persons being prepared in the field and who become recognized to practice speech pathology meet at least the minimum requirements as established by the professional organization in the area of speech pathology.

Departments or agencies of the Federal Government dealing with the speech handicapped should have a continuing program of receiving consultation and

guidance from the speech pathology profession in the implementation of matters dealing with the speech handicapped. This plan applies not only to standards of certification, but to standards of training programs, research efforts, etc.

IV. THERAPIST-TO-PATIENT RATIO

It is vital that the number of patients being seen by speech personnel at any time be such that effective diagnosis and/or treatment can be done. Frequently the speech specialists are faced with the demand of treating very large numbers of children or in other ways have too great demands made upon their services.

Any legislation which influences the caseload of persons in the fields of speech pathology should attempt to guarantee that the efforts of the speech specialist are not diluted. A recognized standard is that in the public school situation 100 individuals is a maximum caseload for a full-time therapist. Among the general population (all ages) available evidence indicates that 1 speech pathologist should be provided for each 50,000 persons in addition to the school population.

It is recognized that geographic area, type of patient handled, and therapeutic needs should influence the ratio of speech pathologist to patients; however, the above represents a meaningful guide for determining such ratios.

V. COORDINATION OF LOCAL SERVICES AND FINDING OF AVAILABLE LOCAL FACILITIES

Throughout the geographic area considered by this workshop there are many agencies, bureaus, offices, clinics, etc., which have services of benefit to the speech handicapped. These may be specific speech therapy programs or they may be other programs which are directly related to the welfare of the speech handicapped individual.

In the past numbers of State departments, as well as private and other agencies, have prepared listings of the various services available. However, such listings have been for only relatively localized geographic areas, for only some of the services available, and typically have not continued beyond the initial effort.

Speech pathologists as well as other professional workers need to coordinate their efforts and to make maximum use of the various facilities available. This need is not only true for patients within a given localized area but also applies to distant geographic areas. In our mobile society individuals frequently change residence, and typically it is difficult for the professional worker to refer the patient to an appropriate service in the area of his new residence.

In order to facilitate the continuing services for patients who change residences and in order to make maximum use of the available facilities, as well as to facilitate the coordination of various services for the speech handicapped, it is recommended that a comprehensive cataloging of services be carried out and be made generally available. Such a catalog should include a wide range of service facilities which bear upon the welfare of the speech handicapped individual, should be nationwide in scope, and be on a continuing basis so that the catalog may be updated periodically.

VI. ORIENTATION OF ALLIED PROFESSIONAL FIELDS AND OF VOCATIONAL TRAINING PERSONNEL TOWARD SPEECH PATHOLOGY

The speech pathology profession recognizes that it cuts across numerous professional areas. However, for the speech handicapped individual the speech pathologist most often is and should be the center about which his rehabilitation program revolves. Other professional areas contribute materially to the rehabilitation of the speech handicapped individual, and not infrequently one of the other professional individuals is the first to be in a position to detect a handicapping speech problem. Thus these other professions (for example, nursing, social workers, physicians, dentists, psychologists) need to have a basic orientation in the recognition of speech disorders and of the necessity for referring a speech handicapped person to the speech pathologist. In addition, vocational training in various trades and technical skills are given by specialists in these areas to the speech handicapped. Such teachers need to have an awareness of the importance of the speech disorders and an understanding of the speech handicapped individual.

Although at the present time this need is met in part, in numerous instances it is not.

This workshop section recommends that there be established additional workshops and inservice training programs for members of other professions and/or persons engaged in teaching vocational skills to the speech handicapped, so that the end result may be more effective rehabilitation for the speech disordered person.

VII. INDEPENDENT LIVING

Among the adult population, particularly the aging but including younger adults, adventitious speech disorders are becoming more common. Existing regulations dealing with the vocational rehabilitation of adults frequently prohibit agencies from providing service to patients who present a poor prognosis for future employability. However, adult patients with a poor prognosis for full- or part-time employment can and should receive the benefits of rehabilitation. Such assistance improves the social-emotional adjustment of these patients and will make it possible for the patient to live on at least a semi-independent basis. As a result, a member of the household who no longer needs to care for the patient can be released for gainful employment, or special daily care need not be continued. It is recommended that the existing criteria for eligibility for rehabilitation services be liberalized so that they will admit speech therapy to individuals who, although not independently employable, can profit from training in the communication skills. The practical result of this liberalization will be seen not only in the patients themselves but in members of their families and associates.

VIII. RESEARCH

The speech profession, although relatively young, has been actively engaged in research for at least the past 30 years. This research has contributed materially toward the understanding of the speech handicapped and methods for their rehabilitation. However, as in many fields of human endeavor, there is a continuing need for research as we gain increased understanding and discover additional prospects for areas of future investigation.

Continuing research at all levels is necessary for the growth of the speech profession; the results will be reflected as better rehabilitation service to the speech handicapped.

The present efforts of a number of governmental agencies which support research related directly or indirectly to speech pathology should be continued and fostered. The workshop group did not undertake outlines of needed areas of speech pathology. However, it is recommended that the publication "Research Needs in Speech Pathology and Audiology," prepared by the committee on research of the American Speech and Hearing Association with support and co-operation of the Office of Vocational Rehabilitation and the Veterans' Administration, be used as a guide when consideration is given to areas of research to be supported by Federal legislative action.

IX. FACILITIES

Throughout the eastern Atlantic region there exists a number of hospitals, universities, and schools which contain suitable facilities for corrective work with the speech handicapped. However, frequently it is difficult to incorporate into buildings the necessary facilities. This is true for hospitals, clinics, universities, and public schools. Too often administrators sacrifice speech pathology facilities in order to conserve construction costs. Thus the speech handicapped cannot be served in appropriate facilities, although facilities would materially benefit their therapy programs.

A study program is indicated to determine not only the status of existing physical facilities for diagnosis and treatment of the speech handicapped, but also to project the exact needs of facilities for dealing with this handicap. In view of the common failure of program administrators to incorporate special speech facilities in their building plans, it is recommended that wherever possible legislation encourage, by appropriate methods, the establishing and equipping of corrective speech facilities. This may be in the form of offering special financial inducements for the addition of such facilities to existing buildings or to including the facilities in new building plans. This should be available not only to hospitals and clinics but also especially to public school facilities.

In addition, the more extensive use of facilities should be encouraged, especially during the summer months when facilities such as public schools are not in use.

Further, in selected geographic areas there are no speech diagnosis and treatment facilities available. Therefore, a part of the study of this problem should include recommendations for establishing such facilities where they do not now exist in any form.

X. OVERLAPPING SERVICE

Although the workshop group, at this time, does not desire to specify examples of overlapping or duplicating services, the group wishes to go on record as being against such duplication. Legislation which will influence programs or facilities for the speech handicapped should avoid costly and unnecessary duplication, although it should in no way inhibit the establishment of facilities and programs as needed.

XI. PROFESSIONAL ADVICE

When considering legislation dealing with the speech handicapped, legislators should at all times have the full benefit of advice and counsel of those whose lifework is with the speech handicapped. This, we believe, contributes materially to the effectiveness of legislation as it relates to the rehabilitation of the speech handicapped. Although members of other professions may be able to make material contributions to this type of legislation, persons actually engaged in speech pathology are the best qualified to give guidance and counsel on these matters. It is recognized that in many instances such counsel has been obtained, and the activities of the present workshop demonstrate this type of counseling in action.

It is strongly recommended that procedures such as the present workshop activities as well as the establishing and use of the advisory committees, individual consultants, and the employment of agency staff members specific to speech pathology be continued.

Such continued consultation is especially evident in view of the rapid growth of the profession of speech pathology, the rapidly increasing fund of knowledge in the area, and needs of our citizens for the types of service offered by the speech pathologists.

THE SPEECH HANDICAPPED SECTION PARTICIPANTS

Eastern Atlantic Regional Workshop
Fels Institute of Local and State Government
Philadelphia, Pa.
February 16-17, 1960

COCHAIRMAN

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- Anne Gray, B.S., M.S., director of speech and hearing, D. T. Watson Home for Crippled Children and Laughlin Children's Center, Sewickley, Pa.
- Murray M. Halfond, Ph. D., director of speech and hearing center and associate professor of speech, Temple University, Philadelphia, Pa.
- Alonzo Hall, B.S., M.A., head, speech therapy department, Harmarville Rehabilitation Center, Pittsburgh, Pa.
- Rev. John P. Hourihan, S.T.L., Department of Special Education, Archdiocese of Newark, N.J.
- Alan B. Jones, state supervisor, Pennsylvania Bureau of Vocational Rehabilitation, Harrisburg, Pa.
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- Michael Marge, Ed. D., associate professor of speech, Montclair State College, Upper Montclair, N.J.
- Jack Matthews, Ph. D., chairman, speech department, University of Pittsburgh, Pittsburgh, Pa.
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- Harold Scholl, Ed. D., chairman, department of speech, Montclair State College, Upper Montclair, N.J.
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- Alice V. Stone, B.A., M.A., Ph. D., supervisor of services in speech, hearing, and vision, Bucks County Public Schools, Doylestown, Pa.
- Elizabeth Walpole, B.A., director of speech center, Cooper Hospital, Camden, N.J., and consultant, Westville School System, Westville, N.J.

Mr. ELLIOTT. Our next witness is Dr. Gordon Connor, executive director, Greater Pittsburgh Guild for the Blind.

Dr. Connor comes to us from the visually handicapped section of the Philadelphia workshop.

STATEMENT OF DR. GORDON CONNOR, EXECUTIVE DIRECTOR, GREATER PITTSBURGH GUILD FOR THE BLIND

Dr. CONNOR. Mr. Chairman, members of the committee, the section of the Philadelphia study which was concerned with the visually handicapped were 28 in number, and they seemed to divide naturally between the field of education and rehabilitation.

So, in the course of their 2-day study, they separated, each working in a different section of the same room, with occasional joint meetings.

I am going to try to highlight the findings of each section which was presented as the joint findings of this particular section and attempt to highlight in 2 or 3 minutes for each section and then respectfully request that the committee accept the written report of this group.

Mr. ELLIOTT. Without objection, the written report of the group on the visually handicapped will be made a part of the record immediately following the oral presentation of Dr. Connor.

Dr. CONNOR. The subject group dealing with the background of rehabilitation generally pointed up the need for a reexamination of the availability of vocational rehabilitation services prior to age 16, feeling that oftentimes this prevents an individual from timely effective services.

This particular group was also concerned with the pending independent living legislation and felt among other things, that there

should be separate programing and staffing, else this particular bill seek to encourage the losing of some otherwise hard-core VR cases.

The section was also interested in the provision of specific reader services to the professionally placed blind person for a minimum of 1 year on a post-training basis, feeling that, for example, the blind person who is placed as a lawyer during his first year or so of employment would find economic hardship and have good use for reader service in addition to the maintenance and other services at that time.

This rehabilitation section was also concerned with the provision of tuition because there seems to be a growing tendency among the several States to place tuition on a needs basis and it is recommended that it be made obligatory upon the several States to provide this service without the individual being required to establish economic need.

In the area of public housing this section of the workshop recommended that due consideration be given to the matter of housing on behalf of blind persons as an unmet need, developing this along the lines of either a preferential or a quota system.

This section also gave consideration to the combined problem of geriatrics and blindness, showing vital concern with the problem of the aged blind person and the need to bring adequate services to this group.

I am fully aware of the fact that the problem of the aged is already of vital concern to the Congress.

The group suggestions that adding the disability of blindness seriously enhances the problem and could stand special study.

The group concerned itself with title II of the Social Security Act, indicating that in some instances there is an element of compulsion toward rehabilitation and the withdrawal of OASI benefits with the refusal to accept rehabilitation and in those instances where this could produce an economic penalty upon the individual or where it might possibly force the individual to stand in either health or physical jeopardy, it is felt this should be interpreted as good cause for the refusal of such services.

The educational grouping of this section pointed up that legislation similar to Public Law 85-926 for the training of both undergraduate and graduate levels for teachers and ancillary personnel in general be provided or that consideration should be given to making funds available for in-service training programs, college or university summer sessions, as well as full-time college or university enrollment.

The educational grouping fully endorsed the recommendations made by the American Printing House for the Blind at the Atlanta, Ga., hearing.

Also, that additional Federal aid should be made available to the State Department of Education and the schools for the blind for the purchase of materials and for equipment necessary to prepare recorded books and hand copied braille or large type books, including the provision of funds for proofreading of such materials by qualified individuals.

Increased subsidy should be given to the American Printing House for the Blind in order to provide additional staffing as pointed up in earlier testimony, additional staffing for the plastic plate braille reproduction process, for the preparation, continuance, and dissemination.

tion of information concerning all available hand copied or pressed braille materials and sound recording.

The group recommended that additional funds be made available to the Library of Congress, division for the blind, to help provide for the following.

You were talking of book reproducers equipped with variable speed motors, more effective distribution of talking book machines, supply of additional and more receptive selections of materials, particular items which would be helpful to the college student and to the professionally employed.

Adequate information as to what titles are available in both pressed and hand copied braille and sound recordings.

The group also suggests that legislation should be enacted to provide Federal funds for the establishment of regional residential diagnostic centers for the multiple handicapped with defective vision.

Funds should also be made available for the purpose of services from these or from any qualified facility already in existence.

Skipping along to highlights here, the group did work on bringing to the attention of the committee the need for Federal funds to provide the schools with equipment and teaching personnel for the expansion of prevocational training programs for visually handicapped children.

Serious consideration should be given to the possibility of securing Federal support in order to make available actual talking book reproduced records and other sound devices.

The study group endorsed the present method of the committee in seeking grassroots information and we feel certain that within the limited time allowed in the workshop that there are many things that have not been touched upon which hopefully will be touched upon in the other regional study groups and in the hearing.

With that, Mr. Chairman, I would respectfully ask if I may submit this for the record, and thank you very much.

Mr. ELLIOTT. Thank you, Dr. Connor.

Without objection, Dr. Connor's statement will be made a part of the record at this point.

(The statement referred to follows:)

SUMMARY REPORT OF THE EASTERN ATLANTIC REGIONAL WORKSHOP ON SPECIAL EDUCATION FOR THE VISUALLY HANDICAPPED, PHILADELPHIA, FEBRUARY 16 AND 17, 1960

The Workshop on Special Education for the Visually Handicapped considered the following to be major problems in this field on which it felt that changes in or extension of existing Federal legislation or introduction of new Federal legislation would effect improvement in services to be rendered:

1. Legislation similar to Public Law 85-926 for the training at both graduate and undergraduate levels of teachers, supervisory and administrative personnel, and auxiliary educational personnel, such as, psychologists, house parents, social workers, and mobility instructors. Consideration should be given to making funds available for in-service training programs, college or university summer sessions, as well as for full-time college or university enrollment.

2. The Workshop participants fully endorse the recommendations made by the American Printing House for the Blind at the Atlanta, Ga., hearings.

3. Additional Federal aid should be made available to the State Departments of Education and the schools for the blind for the purchase of materials and equipment necessary to prepare recorded books and hand-copied braille or large-type books, including provision of funds for the proofreading of such materials by qualified individuals.

4. Increased subsidy should be given to the American Printing House for the Blind to provide additional staff for the plastic plate braille reproduction process, and for the preparation, continuance and dissemination of information concerning all available hand-copied or pressed braille materials and sound recordings.

5. We recommend that additional funds be made available to the Library of Congress, Division for the Blind, to help provide for the following:

(a) Newer talking book reproducers equipped with variable speed motors.

(b) More efficient and adequate distribution of talking book machines.

(c) Supplying additional and more representative selection of materials, particularly items which would be helpful to the college student and the professionally employed.

(d) Adequate information as to what titles are available in both pressed and hand-copied braille, and sound recordings.

6. Legislation should be enacted to provide Federal funds for the establishment of regional residential diagnostic centers for the multiple-handicapped with defective vision. Funds should also be made available for the purchase of services from these, or from any qualifying facility already in existence.

7. New legislation should also be enacted to provide funds for the establishment of regional treatment centers for emotionally disturbed visually handicapped children, requiring residential care, and services should be available to the parents.

8. New or extended legislation is needed so that services now available for physical restoration to clients under vocational rehabilitation and the crippled children's program may be provided to any visually handicapped individuals needing such service.

9. Federally supported research programs which would be of chief concern to special education for the visually handicapped would include:

(a) Exploration of types of materials for individuals having partial vision, i.e., print of varying sizes, magnifiers, more effective recording materials.

(b) Continued and increased support for studies on causes and prevention of blindness.

(c) Social and educational implications of specific eye defects.

(d) Development of better diagnostic and evaluation services and tests for visually handicapped children.

(e) Methodology for training brain-injured visually handicapped children.

10. Federal funds to provide the schools with equipment and teaching personnel for expansion of prevocational training programs for visually handicapped children.

11. Provision for additional Federal income tax exemption to be extended to include any blind dependent.

12. Publication of a digest of new legislation and regulations and pertinent activities covering all Federal programs for the handicapped to be distributed to individuals working in the various fields.

13. Serious consideration should be given to the possibility of securing Federal support to make available talking book reproducers and records, other sound recordings, large print and other special materials and devices for those whose visual activities exceed the legal definition of blindness and yet who, because of their visual limitations, require such materials.

Those who attended the Workshop for the Visually Handicapped on February 16-17, 1960—Rehabilitation Section:

Norman Yoder, Ph.D., cochairman, commissioner, State office for the blind, Harrisburg, Pa.

George E. Burck, State Council of the New Jersey Organizations of the Blind.

Gordon E. Connor, Ph.D., director of rehabilitation, Greater Pittsburgh Guild for the Blind, Pittsburgh, Pa.

Frank J. Cummings, Ph.D., Delaware Commission for the Blind, Wilmington, Del.

Frank E. Gable, Philadelphia Working Home for the Blind, Philadelphia, Pa.

Phillip N. Harrison, Pennsylvania Association for the Blind, Harrisburg, Pa.

Mrs. Phillip Harrison, Pennsylvania Association for the Blind, Harrisburg, Pa.

Howard T. Jones, Delaware Commission for the Blind, Wilmington, Del.

Joseph Kohn, New Jersey State Commission for the Blind, Newark, N.J.

Marion McVey, assistant regional representative (region 2), Office of Rehabilitation.

George F. Meyer, New Jersey State Commission for the Blind, Newark, N.J.

Henry G. Roberts, American Foundation for the Blind, New York City, N.Y.

John Taylor, National Federation of the Blind, Washington, D.C.

William Taylor, Pennsylvania Federation of the Blind.

Those who attended the Workshop for the Visually Handicapped on February 16-17, 1960—Special Education Section.

Alton G. Kloss, Ed.D., cochairman, superintendent, Western Pennsylvania School for Blind Children, Bayard Street at Bellefield, Pittsburgh, Pa.

Francis N. Andrews, superintendent, Maryland School for the Blind, Baltimore, Md.

Mary K. Bauman, Personnel Research Center, Philadelphia, Pa.

Rita Drill, Pennsylvania Federation of the Blind, Philadelphia, Pa.

Jane D. Ellen, Maryland Society for the Prevention of Blindness, Baltimore, Md.

Dorothy R. Hartman, National Society for the Prevention of Blindness, Philadelphia, Pa.

Joseph J. Kerr, Overbrook School for the Blind, Philadelphia, Pa.

Elinor H. Long, Pennsylvania Department of Public Instruction, Harrisburg, Pa.

Virginia Macool, Pennsylvania Federation of the Blind, Philadelphia, Pa.

Edythe K. Moore, Pennsylvania Working Home for the Blind, Philadelphia, Pa.

John F. Nagle, National Federation of the Blind, Washington, D.C.

Kingsley Price, Ph.D., National Federation of the Blind.

Josephine L. Taylor, New Jersey Commission for the Blind, Newark, N.J.

Sara R. Weaver, Newark, N.J., Public Schools.

EASTERN ATLANTIC REGIONAL WORKSHOP ON THE VISUALLY HANDICAPPED

Cochairmen: Dr. Alton Kloss, superintendent, Western Pennsylvania School for the Blind, Bayard at Bellefield, Pittsburgh, Pa., and Dr. Norman Yoder, director, State commission for the blind, Harrisburg, Pa.

Reporting to the Subcommittee on Special Education at congressional hearings: Dr. Gordon Connor, executive director, Greater Pittsburgh Guild for the Blind.

The workshop dealing with the visually handicapped individual and the problem of the unmet needs in this area analyzed a series of propositions and submit for congressional consideration the following recommendations.

These recommendations are submitted with no estimate of potential cost because, to do so would involve a lengthy and more detailed study than the workshop time permitted. However, it is the consensus of opinion presented that the recommendations contained herein would not materially require budgetary increase.

It is our general thought that a more expedient use of moneys already appropriated would cover the basic increases stemming from these recommendations.

PROVISION OF REHABILITATION SERVICES PRIOR TO THE AGE OF 16

The workshop committee concerned itself with the provision of vocational rehabilitation services prior to the age of 16. While many State agencies assume this responsibility under "diagnostic procedures," nevertheless there is little, if any, basis for the provision of case services prior to that age.

Both special education adherents and vocational rehabilitation adherents believe that it is important for case services on a purchased basis to be made available as early as the freshman or sophomore year in high school in order to correct, to alleviate and/or to strengthen those areas of physical disability which may be a barrier to later sound rehabilitation.

The workshop committee in no way recommends that because work begins at an earlier age than that of 16, that private, public, and/or other school authorities be relieved of their respective responsibilities in carrying out those elements usually assigned to the educational facility.

We recommend that for clarity purposes, congressional or administrative action be taken to either amend the existing legislation or clarify the regulations issued pursuant thereto for the purposes of obtaining these objectives.

INDEPENDENT LIVING

The workshop is not recommending any specific piece of legislation now pending before the Congress on the subject of "Independent Living." However, it feels that the provisions in this legislation will furnish services not now

available to a great number of individuals who, because of the complexity of their disabilities are not feasible for vocational rehabilitation.

Recommendations to broaden existing legislation to include the philosophy of independent living, are submitted, but it is also suggested that some definitive guidelines be included in any legislation on this matter.

These guidelines are: (1) that under no circumstances should the impetus to job finding (placement) be lessened because of opportunities presented under independent living legislation; (2) that in order to bring about a more definitive approach to placement, the Congress require uniform standards for measuring rehabilitation nationally. Such standards may include a minimum earned income or other factors. (3) that a separate staff and programing be applied to the independent living program.

The workshop believes that there is an inherent danger in approaching such legislation without specific guidelines to carry out the intent and at the same time to preclude a disregard of the necessity to find jobs for the employable blind.

PROVISION OF READER SERVICES

The committee recommends that the provision of reader service be removed from any needs test, since the necessity for this service is an essential part of the educational process because of blindness.

In addition, the workshop recommends that reader service be provided on a posttraining basis for a minimum of 1 year.

This becomes essential to protect the already heavy investment in the education of the blind person. Experience demonstrates that without the provision of adequate posttraining reader service a blind person may find it impossible to succeed professionally in competition with a sighted individual.

PROVISION OF MAINTENANCE AND OTHER SERVICES

The workshop examined the necessity for expanding that phase of the rehabilitation program dealing with postplacement services, namely, maintenance and the provision of other services.

At the outset, it does not seem reasonable that 30 days of maintenance is adequate in those instances when an individual expects to become self-employed or if he is working in a contract situation.

The attorney, the chiropractor, and those in similar occupations, while they may open a practice, seldom, if ever, in the first 30 days have an adequate income to maintain their office and to maintain themselves. We, therefore, believe that administrative interpretation or legislative amendment should remedy this situation.

Moreover, because employment opportunities frequently require the rental of space, the rental or subsequent purchase of equipment, that the provision of these services should be available after the initial placement has been made.

The workshop further recommends that there be a realistic definition of "a reasonable period of time" to be established as 1 year, rather than 30, 60, or 90 days.

PROVISION OF TUITION

Because there is a growing tendency among the several States to place tuition on a needs basis, it is recommended that it be made obligatory upon the several States to provide this service without the individual being in economic need.

The workshop takes cognizance of the fact that under current Federal legislation the needs test is not required, but we also take cognizance of the fact that budget officers within the several States are forcing rehabilitation agencies to apply such needs tests in increasing numbers.

PUBLIC HOUSING

The workshop recommends that due consideration be given to the matter of housing on behalf of the blind as a basic unmet need. While it may not be within the purview of this specific committee of Congress to consider this problem, we feel that it is necessary to call it to congressional attention, for adequate housing is the basis on which sound and long-range rehabilitation of an individual can be accomplished.

The workshop in examining this problem suggests that either a preferential or quota system may be considered on behalf of the blind in public housing authori-

ties in order to remove these individuals, because of economic necessity, from blighted or slum areas.

GERIATRICS AND BLINDNESS

The workshop personnel is vitally concerned with the problem of the aged blind person and the need to bring adequate services to this group. Recognizing the basic principle that the problem of the aged is already of vital concern to Congress, we suggest that adding the disability of blindness seriously enhances the problem and, therefore, should, as a result of this study, require special mention.

In general, it is the feeling that the basic principles in legislation now pending before Congress afford an initial step in providing these services to the aged blind, as well as to other older groups of our citizens.

The workshop strongly recommends that provision be made to bring knowledge from the field of geriatrics and the field of blindness together for the advantage of the aged blind population.

TITLE II. SOCIAL SECURITY ACT

An examination of the present provisions of title II of the Social Security Act clearly indicates that there is an element of compulsion which is both inequitable and dangerous. It does not seem realistic to the workshop personnel that sound rehabilitation would be based upon the requirement that an OASI recipient accept vocational rehabilitation or risk losing his disability payment.

We recognize that title II does provide limited exceptions to this concept. However, there are instances available that blind individuals were required to accept employment with less remuneration than their OASI disability payments, with the end result that an actual financial hardship was worked upon the person.

It is, therefore, recommended that the rule requiring the OASI recipient to submit to rehabilitation, except for "good cause" be more liberally interpreted in order that the individual not be placed in a position of: (1) economic loss or penalty, or (2) physical or health jeopardy. The blind person should receive every encouragement to accept rehabilitation services when practicable.

RANDOLPH-SHEPPARD ACT

The workshop personnel recommends that the provisions of the Randolph-Sheppard Act be strengthened to preclude the continuing encroachment of vending machines on Federal property, thus materially reducing the income to blind vending stand operators and more especially, in certain instances, making the business so unprofitable that the stand location needed to be terminated.

Secondly, it is the committee's recommendation that this act be broadened in its scope to permit "a snack bar arrangement," rather than the present concept of a "dry stand," on such Federal property.

Thirdly, because there appears to be a continuing problem of policy development at the Federal level on an interdepartmental basis in the securing of vending stand sites, we recommend that some method specifically outlined for appeals be adopted and that such a board have a final decision as to the advisability and feasibility of the vending stand location, and that the decision of this appeals body be binding upon Federal bureaus, departments, agencies, etc., as well as the State agency making that appeal.

PROFESSIONAL PLACEMENT OF THE BLIND

The committee believes that it is incumbent upon them to recommend endorsement of the present activities instituted by Services for the Blind, Office of Vocational Rehabilitation, in developing a teachable body of knowledge regarding placement opportunities for the blind in the professions. This study as it is now proposed will, the committee believes, open up an entirely new and remunerative field of employment for trained blind individuals. When necessary it is hoped that the Congress will consider appropriate legislation on certification, licensing, and boarding when such action will not contravene State prerogatives.

RESEARCH

The workshop endorses research activities now in process on behalf of the blind, but the committee views with regret a number of research projects which

appear to have been undertaken without sufficient examination and thought as to their practicality. The study group is also vitally concerned with the tendency to shift emphasis in certain research areas to the exclusion of necessary study of problems related to blindness.

We cite only one example to illustrate this point; namely, that there has been a decrease in the moneys expended by the Institute on Neurology and Blindness for the latter phase of the work. Ophthalmological research is vital to the prevention and to rehabilitation of a large segment of our present population.

We endorse the philosophy of research as a means of bridging existing gaps in needed services to the blind.

COORDINATION OF SERVICES FOR THE BLIND

It is apparent that the present study and series of hearings already points up the need for coordination of services for the blind at the Federal level. While it would appear to be administratively impossible to bring all segments of Services for the Blind together in a single administrative unit, it is apparent to the Workshop Committee that there has been a decided lack of coordination, communication, and transmittal of vital information which would have been of material benefit to the State agencies, private agencies, and organizations of and for the blind.

STRENGTHENING ADMINISTRATION

The group was of the opinion that by expanding the consultative function of the central office, Services for the Blind, Office of Vocational Rehabilitation, more effective work could be done with the State agencies, private agencies, organizations of and for the blind, and this could be achieved by some slight additions in and sufficient budget increase to enable the office to carry out this enlarged activity nationally.

SUMMARY

The study group endorses the present method of seeking "grass roots" information for the committee's consideration. We feel sure that within the limited time permitted this workshop has not examined all of the unmet needs of the blind. We do, however, feel that the time allocated to us gave the group of educators, rehabilitation personnel, and organizations of and for the blind an opportunity to examine, to evaluate, and to recommend for the committee's consideration certain steps to alleviate the condition of unmet needs.

(The following statements were submitted for the record:)

STATEMENT OF CONGRESSMAN PETER W. RODINO, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. Chairman, I want to thank the committee for the opportunity to express my interest and concern in this vital matter.

Until comparatively recently, the handicapped individual had little or no productive role in society. He was usually a burden both on the public and on himself, and if he was severely handicapped he could not hope to find, in life, any substantial fulfillment.

Now the picture has radically changed. Both in the areas of physical disability, and in the fields of mental retardation and emotional disturbance, medical science has made such headway that we now know a great deal can be done to rehabilitate these individuals and prepare them for a life of happiness and productivity.

Private foundations and local authorities have all made significant strides. An increasing number of people are being helped and rehabilitated. Particularly is this true in the State of New Jersey, which has long been concerned with the problem.

But as it becomes increasingly clear that science can help more people, the greater the task becomes. Successful experimentation makes it more and more apparent that much could indeed be accomplished if there were enough teachers, enough therapists, enough facilities and special equipment.

It is obvious that private endowments and local authorities cannot cope with the problem alone. The Federal Government must take over some of the re-

sponsibility. Just as, for example, we are already providing fellowships for the training of teachers for mentally retarded children, under Public Law 85-926, we should be taking similar steps in the areas of emotionally disturbed or deaf children. And, just as we help to rehabilitate our veterans, we should also share that responsibility for other elements of our population.

The Federal Government cannot, of course, do everything. But this is a field where a relatively small expenditure can save millions of people from a life of emptiness. If we must speak in monetary terms, let us say that the gain to our economy of these potentially productive individuals surely justifies the expenditure.

I think this committee is doing a great service by investigating the needs in this area. The problems of the physically handicapped, the disturbed, and the retarded are problems of national concern, and I hope that out of these hearings will emerge some workable and forward-looking definition of Federal responsibility and obligation.

STATEMENT BY IRVING W. SHANDLER, DIRECTOR OF PATIENT SERVICES, PENNSYLVANIA TUBERCULOSIS AND HEALTH SOCIETY

Mr. Chairman, I am highly honored by this opportunity to appear before this distinguished committee.

Since I am, by profession, a medical social worker and my current position with the Pennsylvania Tuberculosis and Health Society, I would like to focus my remarks on the field of tuberculosis, particularly the rehabilitation aspects of tuberculosis control. And, since my experience has been primarily in the Commonwealth of Pennsylvania, my remarks will be made with reference to that area. However, the problems presented here are essentially the same problems faced by the States of New Jersey, Delaware and Maryland.

Considerable progress has been made in the past decade in sharply reducing the tuberculosis mortality rate. At the same time, the morbidity rate has been reduced at a somewhat lower rate.

For example, in Pennsylvania, the mortality rate in 1945 was 41.9 per 100,000 population. In 1955, it was 11.1 per 100,000 and in 1958, 9.2 per 100,000. The morbidity rates for the same years are as follows: 1945, 48.8; 1955, 63.4; 1958, 64.1. (It should be noted that beginning in 1953, more effective reporting of cases has increased the number and somewhat affected the trend. However, the basic difference between the mortality decline and morbidity rate is obvious.)¹

Much of this decline has been due to the discovery and use of chemotherapy and new surgical techniques. Today, many patients who would have been claimed as tuberculosis death statistics are hospitalized, treated, and then returned to the community. Many of this group present a large financial and social problem.

It is at this stage that the full importance of the bill, H.R. 3465 is recognized. The rate of tuberculosis today is found to be higher among older persons, nonwhites and among men.

New active cases reported per 100,000 population in the Commonwealth of Pennsylvania for 1958 indicated:²

Total population-----	40.0	White population-----	29.2
Under 15 years-----	7.3	Male-----	42.9
15 to 24-----	22.1	Female-----	15.9
25 to 44-----	43.5	Nonwhite population-----	168.1
45 to 64-----	64.8	Male-----	215.4
65 and over-----	75.5	Female-----	123.5

Fifty-four percent of the new active cases were of persons 45 years of age and over; 71 percent were white and 29 percent, nonwhite; 69 percent were males and 31 percent, females.

When considered in terms of the Pennsylvania tuberculosis hospital population, it was noted that—

¹ Source: Commonwealth of Pennsylvania, Department of Health, Division of Statistics and Records.

² Source: Commonwealth of Pennsylvania, Department of Health, Division of Statistics and Records.

- (a) More than 50 percent of admissions were over age 45.²
- (b) An estimated 30 to 35 percent of the patients were identified as alcoholics or problem drinkers.³
- (c) Just under two of every three patients were social isolates with essentially no family contact (single, divorced, widowed).³
- (d) Approximately one out of every three admissions left the hospital against medical advice.³
- (e) Based on a recent study conducted by the National Tuberculosis Association, the average reading and comprehension level of the patient population was that of the fourth grade.⁴

Needless to say, this is a group of patients who are in need of considerable help beyond the medical. Many need retraining for placement, counseling and aid for independent living and the sheltered workshop type of setting that assists in their work evaluation, placement in competitive industry or merely a place to work.

The intent of H.R. 3465 appears to recognize many of the needs of the tuberculous as well as other disabilities. The bill asserts the true philosophy of rehabilitation in that it goes beyond the "vocational" aspects. Many applicants seeking services who were not accepted for services due to advanced age, degree of disability or poor vocational outlook might now gain the benefits of professional services with the accompanying rewards of the dignity of independent living.

I am certain that the 65 affiliated organizations throughout the Commonwealth and more than 2,000 workers and board members will heartily endorse this bill.

I would like to specially emphasize two of the points made in section 205(a) (3) and (4):

3. The recognition of the need for trained personnel to implement the intent of the bill. No act or concept has any real value unless appropriate personnel are available to translate philosophy into action. Serious shortages exist in all of the paramedical professions involved in the rehabilitation of the physically and mentally handicapped individuals. Recognition of these shortages and the continued publicity and financially attractive scholarships and fellowships is one step in assisting recruitment in these fields.

4. The recognition of the need for the dissemination of information gained from various demonstration areas and research projects. No research or demonstration is ever wasted in that much can be learned from the failures as well as successes. Making such information available to all interested in rehabilitation is an obligation of those involved in research and demonstration activities.

In the letter of invitation from Mr. Elliott, he indicated that the committee would welcome "specific suggestions as to how the Federal Government might aid the States and local committees in attempting a solution to some of these pressing problems."

The principal additional need in tuberculosis control in the Commonwealth of Pennsylvania is for financial assistance from the Federal Government for the care and rehabilitation of individuals who have tuberculosis and who are living in a State where they have not established legal residence. Numerically, this group has not been large. However, when they do occur, their care and disposition are usually a problem. The current policy is to treat them at the Commonwealth's expense in one of the Commonwealth's hospitals and then try to arrange for their return to the State of their legal residence through the Department of Public Welfare as soon as they are noninfectious. This often requires a considerable period of time and can present many complications.

Again, may I offer my congratulations for your efforts in the construction of the bill and my appreciation for the opportunity to appear before this group.

² Source: Statistical report received from the medical social workers at the Pennsylvania tuberculosis hospitals in September 1958. A later check with the hospitals indicated that the statistics reported in 1958 are essentially the same as of this date.

⁴ Source: Focus, issues 19A and 20A, March 1958. Published by the National Tuberculosis Association, New York.

COMMONWEALTH OF PENNSYLVANIA,
DEPARTMENT OF PUBLIC WELFARE,
Harrisburg, February 24, 1960.

HON. CARL ELLIOTT,
Chairman, Subcommittee on Special Education, Committee on Education and Labor, House Office Building, Washington, D.C.

DEAR CONGRESSMAN ELLIOTT: The Pennsylvania Department of Public Welfare administers several programs which involve the subjects with which your subcommittee is concerned. Our institutions for the mentally retarded carry on programs of special education and while our office for the blind does not conduct formal education, it is interested in the quality of instruction given blind and visually handicapped children and young people. In respect to rehabilitation, our offices of public assistance and children and youth are involved in the social rehabilitation of families; our mental health institutions collaborate with the bureau of vocational rehabilitation, department of labor and industry, on plans for patients ready for discharge; our office of the blind administers the vocational rehabilitation for blind and visually handicapped persons; our office for the aging is encouraging county homes, nursing homes, and similar facilities which it supervises to establish programs of physical rehabilitation.

It is the experience of this department that there is no one goal and no single method of rehabilitation. Indeed, in outlining to you our interests in this field, I have referred to social, vocational, and physical rehabilitation. Coordinated use of a variety of skills is the program emphasis of this department. For example, the rehabilitation of a patient who has been mentally ill involves not merely psychiatric treatment. His return to the community may require preparation of the family by hospital social service, vocational counseling, and placement by the department of labor and industry, referral to a community outpatient clinic for continued treatment. Rehabilitation of the patient is the result of the efforts of people who belong to many professions; it is not the sole province of a single discipline. This is equally true of the "rehabilitation" of a handicapped child, a family long dependent on public assistance, or of an aged person bedfast through lack of incentive and stimulation.

This department believes that grants for projects demonstrating methods of promoting self-help and independent living should be made not just to vocational rehabilitation agencies but to a variety of voluntary and governmental medical, welfare, and rehabilitation services.

We have the following specific suggestions to make respecting vocational rehabilitation:

In the area of vocational rehabilitation for the blind, it becomes increasingly apparent that Public Law 565 of 1954, and the related regulations, are too restrictive in the provision of post professional placement service. At present, State agencies can provide service after placement for a 30-day period or until a first paycheck is received, whichever is first.

In placing attorneys, social workers, schoolteachers, and others, one of the keys to success is the provision of reader and similar service for a period ranging from 6 months to a year, until the individual is so established that he can assume this burden on his own, either through marriage, or the employment of usual stenographic assistance.

We suggest that the committee be concerned with the fact that faculty members in schools for the blind need not achieve the same academic status as teachers in similar grades in the public schools. We believe that this is both an injustice to the student and in many instances a serious handicap to good vocational rehabilitation after graduation.

We would suggest that in vocational rehabilitation some additional latitude be given in the diagnosis of applicants. While a degree of latitude exists, if this were spelled out more thoroughly, either in the law or regulations, it would give the State agency opportunity to explore fully the maximum capacity of the individual and would, in effect, serve much of the purpose of the independent living bill.

We further suggest that some provision and consideration be given to reaching the high school student prior to the age of 16 in order to provide counseling, guidance, and other services in cooperation with the school authorities.

We believe that a serious question must be raised regarding the overall benefits derived from the present advanced training of vocational rehabilitation counselors at the university level. It is our experience in Pennsylvania, that the coordinators of these programs who screen candidates for training do not in-

clude representatives of the rehabilitation agencies. Moreover, the rehabilitation agencies in Pennsylvania are getting relatively few people from this source of trained personnel, mainly because they come from the field of education, and with a master's degree in counseling, can return to the public schools at better salaries and longer vacations than State agencies can provide.

We suggest that while there is continuing need for research and demonstration projects, there ought to be a more effective clearinghouse for approval of projects than now exists.

This Department is concerned with special education since it is used in institutions for the mentally retarded. Our experience with institutionalized persons who are mentally handicapped (who may also be physically handicapped) indicates the necessity for teachers and vocational counselors to be part of the institutional team. This means not only that their activities must be psychiatrically supervised but that their professional preparation must be psychiatrically oriented. We believe that Federal mental health grants now available for the training of psychiatrists, psychologists, social workers, and nurses should be extended to the preparation of teachers and vocational counselors who will work in institutions for the mentally retarded and emotionally disturbed.

Before grants for psychiatrically oriented teacher training are established, however, education, psychiatry, and psychology must work out curriculum content and criteria for approved training facilities. This work should be initiated by pilot projects in which selected institutions for the mentally retarded and emotionally disturbed would collaborate with universities having approved special education programs. The results of the pilot projects should then be compiled to form the basis for the development of a nationally accepted program of special education in a psychiatric setting.

We believe that the greatest potential hazard in this total field is the lack of coordination among the vast array of agencies working in this field.

While it is true that a great many different and sometimes specialized services are required in each community, we are concerned that the handicapped individual and the family not be lost among them. With the very best of intentions, each of several agencies often become involved in one aspect of a situation with none taking basic responsibility for the ultimate result. We believe that Federal agencies which stimulate, encourage, and support so many local services should be concerned about this matter. They should strive to help us all achieve a maximum of integrated effort in order to make the most efficient and effective use of scarce dollars and hard-to-get personnel.

We are happy to have had this opportunity to express our point of view. Please call upon us if we can be of further service.

Sincerely yours,

Mrs. RUTH GRIGG HORTING, *Secretary.*

MARYLAND STATE DEPARTMENT OF EDUCATION,

STATE OFFICE BUILDING,
Baltimore, February 26, 1960.

HON. CARL ELLIOTT,
House of Representatives, Washington, D.C.

DEAR CONGRESSMAN ELLIOTT: My appearance before your committee at the hearings in Jersey City on Thursday, February 18, 1960, was canceled because of illness. I regret that I lost the opportunity to testify in behalf of the Maryland State Department of Education. I should therefore like to have this letter inserted in the record of your proceedings, in order that you may have a statement from the department.

As I indicated in my letter of July 30, 1959, educational programs for exceptional children and youth in Maryland, although they have greatly expanded during the past 6 or 7 years, have not been extensive enough to meet the needs. The growth has been steady, however, and it will continue, provided that Maryland meets her own responsibilities; and

Provided, further, that research concerning the education of exceptional children is encouraged, coordinated, and disseminated, since sound programs should be based on the findings of research;

Provided that a sufficient number of institutions of higher learning offer appropriate sequences in the various categories of exceptionality, in order that teachers may become proficient in their teaching;

Provided that qualified leaders are developed to prepare teachers of exceptional children and youth, and to supervise programs;

Provided that the U.S. Office of Education provides opportunities for State directors of special education and members of their staffs to confer annually on important professional problems;

Provided that the Section on Exceptional Children and Youth of the U.S. Office of Education has the responsibility for the professional aspects of all programs which Congress authorizes with respect to special education;

Provided that special education and rehabilitation, each with clearly defined and distinct programs, work out cooperative relationships to foster the well-being of the handicapped (in our opinion, rehabilitation does not concern the gifted as such.)

The responsibility for developing and carrying out the program of special education in Maryland rests with the State and local departments of education in Maryland. Nonetheless, the Federal Government can render valuable service by—

Extending the fellowship program of Public Law 85-926 into all categories of exceptionality;

Encouraging, coordinating, and disseminating research in special education, possibly through a research institute;

Providing opportunities for State directors of special education to confer under the auspices of the U.S. Office of Education;

Increasing the personnel of the Section on Exceptional Children and Youth of the U.S. Office of Education to allow the Section more readily to fulfill its responsibilities in connection with federally authorized programs and to improve the professional guidance given to State departments of education.

The task of providing improved educational programs for exceptional children and youth requires the best efforts of all those engaged in it. We in Maryland, having committed ourselves to a high-quality program, are striving to develop whatever facilities are possible within the public school framework. We acknowledge with gratitude the assistance of nonpublic school groups within the State and the support from Federal programs now in existence. We shall welcome additional assistance along the lines indicated in this letter.

We thank you for the opportunity to express our views.

Sincerely yours,

GENEVA ELY FLICKINGER,
Supervisor of Special Education.

MARCH 3, 1960.

Congressman LAURENCE CURTIS,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN CURTIS: Our organization, which represents parents of deaf children, is writing to ask your help in securing the passage of Senate Joint Resolution 127.

This legislation is designed to help alleviate the national shortage of classroom teachers of deaf children, speech pathologists, and audiologists through scholarships and grants to training centers.

As parents of deaf children, we are particularly concerned with the teacher shortage. The Department of Health, Education, and Welfare states that the greatest teacher shortage exists in this area of exceptionality. Approximately 500 additional teachers are needed for next fall and training centers have turned out only 125 this year.

As parents we are vitally concerned that our children not be denied educational opportunity because of the teacher shortage. There are some 30,000 deaf children of school age whose parents are anxiously concerned about the increasingly desperate teacher shortage. With proper education we can expect that our children will grow up to be useful, productive citizens. Over the past 10 years enrollment of deaf children in schools for the deaf has increased about 400 per year. Last year the increase was 900.

Providing trained teachers of the deaf must become a Federal concern because individual States have no training facilities. There are 22 accredited training centers in this country. With additional funds they could provide a substantially greater number of teachers.

Organizations which have united to secure the passage of the proposed legislation are the Alexander Graham Bell Association for the Deaf, the Conference of

Executives of American Schools for the Deaf, the Convention of American Instructors of the Deaf, and the Parents Section of the Alexander Graham Bell Association.

We would appreciate your support of this legislation.

Sincerely yours,

SUMNER L. SHIR,

Chairman of the Convention Committee, Massachusetts Parents Association of the Deaf and Hard of Hearing.

Mr. ELLIOTT. Now we bring to a close the day's hearings by thanking the board of freeholders of Hudson County and their supervisor, Mr. Thomas Gangemi, for making this nice hearing room available to us today.

The hearings for tomorrow will be held not in this room, but on the first floor of this building, in the county register record room, which is located, as I understand, on your right as you enter this beautiful building.

We meet at 9:30 in the morning.

We have another 42 witnesses to hear tomorrow. Thank you.

(Thereupon, at 6:20 p.m., the subcommittee was recessed, to reconvene at 9:30 a.m., Friday, February 19, 1960, in Jersey City, N.J.)

SPECIAL EDUCATION AND REHABILITATION

FRIDAY, FEBRUARY 19, 1960

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON SPECIAL EDUCATION
OF THE COMMITTEE ON EDUCATION AND LABOR,
Jersey City, N.J.

The subcommittee met at 9:30 a.m., pursuant to recess, in county register record room, Hudson County Administration Building, Hon. Carl Elliott (chairman of the subcommittee) presiding.

Present: Representatives Elliott, Daniels, Giaimo, and Quie.

Also present: Dr. Harry V. Barnard, clerk of the subcommittee.

Mr. ELLIOTT. The committee will be in order.

Mr. Herbert E. Rickenberg will be our first witness. He is director of the eye and ear infirmary unit, Henry C. Barkhorn Memorial Hearing and Speech Center, Newark, N.J.

We are happy to have you, Mr. Rickenberg. You may proceed for 10 minutes.

STATEMENT OF HERBERT E. RICKENBERG, DIRECTOR, EYE AND EAR INFIRMARY UNIT, HENRY C. BARKHORN MEMORIAL HEARING AND SPEECH CENTER, NEWARK, N.J.

Mr. RICKENBERG. Mr. Elliott, gentlemen, I am honored to address the committee this morning in order to discuss hearing and speech rehabilitation in the State of New Jersey.

First, may I introduce myself. I am consultant audiologist-speech pathologist and supervisor of the hearing and speech program of the division of chronic illness control of the New Jersey State Department of Health.

I am president of the New Jersey Speech and Hearing Association; director of the Henry C. Barkhorn Memorial Hearing and Speech Center of the eye and ear infirmary unit of the United Hospitals of Newark, and director of the Henry B. Orton Memorial Speech Clinic for Laryngectomies of Presbyterian Hospital unit of the United Hospitals of Newark.

The State of New Jersey is made up of 21 counties. At this date six counties have active hearing and speech centers in a hospital setting, a seventh county will have a center initiated in the immediate future. Fourteen counties have no hearing and speech facilities available to the general public.

There are approximately 5,749,000 people in the State of which 920,567 were registered as of June 1958 in public day schools.

Considering that the incidence of hearing loss in school children is 3 percent then 27,617 are in need of detection for possible medical intervention as a means of alleviating their deafness.

Approximately 1 percent of the school population have permanent nonreversible hearing losses or a population of 9,205 children. This group is in need of a prosthetic device, auditory training, lip reading, and speech correction and conservation.

If we further consider that 5 percent, or, as the case in New Jersey indicates, 46,028 children have speech defects, then the aforementioned figures realize a total population of 55,233 school age children in need of speech and hearing services.

Since there are approximately 4,828,433 adults in New Jersey and 2.1 percent, or 101,397 may have hearing losses and 3 percent or 144,853 may have speech defects, then the aggregate population of hearing and speech impaired in the State of New Jersey is 301,483 individuals.

Since the possible hearing and speech handicapped population is 300,000 individuals in New Jersey, the division of chronic illness control of the New Jersey State Department of Health in May 1954, activated a joint program with the Newark Eye and Ear Infirmary Hearing and Speech Center. This program is designed through early detection to prevent through medical intervention and rehabilitation debilitating hearing and speech impairments.

Demonstration hearing and speech centers were activated at the Hunterdon Medical Center, in Flemington, N.J.; St. Francis Hospital, in Trenton, N.J.; and Bergen Pines Hospital, in Paramus, N.J.

A fourth center is to be activated this spring at Children's Seashore House in Atlantic City, N.J.

These centers are initiated as a means of demonstrating to the hospital administration and the community the need of such a program.

Application has been made for consideration of a similar project in Warren County.

As of this date there are no facilities in its medical or educational institution.

An example of patient care for the year 1959 is indicated by the following figures. Five employed professional personnel at St. Francis, Hunterdon, and Newark Eye and Ear Infirmary, had an initial intake of 1,301 new patients for a total of 7,190 patient visits.

The initial intake is of further interest when over 50 percent, or 754 adults, were seen in the 1,301 new patient visits.

Further breakdown indicates 193 preschool children and 354 school-age children.

The function of each center is not only patient care within the physical facilities of the center; hearing and speech surveys are conducted in the community. Dissemination of information are continual activities of the centers.

Some of the projects include inservice training programs for school administrators, teachers, psychologists, medical social workers, and public health nurses, explaining and demonstrating speech and hearing therapy as a rehabilitative prevention of debilitating handicaps.

Exhibits are presented at county health fairs and State medical conventions to indicate available facilities.

A recent hospital survey of hearing and speech facilities indicated a few active projects. Most of the programs are centralized in Essex County.

Here in Hudson County there is no public project. There are an estimated 2,500 aphasics in the State of New Jersey, yet there is only one intensive rehabilitative care program in the State.

What professional personnel do we have in the State? The American Speech and Hearing Association lists approximately 100 individuals residing in the State of New Jersey; 5 are not employed in the State; 7 employed in the State hold advanced certification in speech; 26 have basic certification in speech; and 1 has basic certification in hearing.

There are approximately 167 therapists with no clinical certification that are registered with the New Jersey Speech & Hearing Association that are employed in positions where they are supervised by certified personnel.

But if we consider that there are approximately 55,000 school-children with speech and hearing impairments, this leaves a caseload of 276 individuals per therapist. This does not consider the 246,000 adults.

This problem can be amplified to a greater extent. But let us consider the college programs in the State.

There are 23 universities, liberal art colleges, and professional and technical colleges in the State. Approximately six of the colleges have a program in speech and hearing of some sort, yet there is no doctorate program available in speech and/or hearing in the State.

One of the problems faced is a matter of economics.

The colleges must have a certain number of registrants per course, or the class is canceled.

Since there is no doctorate program there is little recruitment of graduate candidates. Personnel to be obtained through graduate programs then must be increased. Since the colleges work on the basis of registrants for a course, the need for House Joint Resolution 494 is critical if we are to service the hearing and speech impaired in the State of New Jersey.

The division of chronic illness control is interested in providing services for the possible 301,483 hearing and speech impaired. There are 14 counties in the State that have no facilities. Moneys are needed to develop these facilities and personnel are needed to man them.

What of the established facilities?

The Henry C. Barkhorn Memorial Hearing and Speech Center of the Eye and Ear Infirmary United of the United Hospitals of Newark now services a medical staff of approximately 400 men. At its inception it served the medical staff of a specialty hospital. Today it serves the staff of the largest hospital in the State of New Jersey.

The United Hospitals of Newark is composed of Presbyterian Hospital, a general hospital;

Babies' Hospital, a pediatric hospital;

Crippled Children's Hospital, an orthopedic hospital; and

The Eye and Ear Infirmary.

Affiliated with the United Hospitals of Newark is the Kessler Institute of Rehabilitation.

Within a year a new structure will be erected for the four hospitals. Plans call for a division of rehabilitation for acute care, and the Kessler Institute in West Orange for intensive care.

The hearing and speech center as contemplated will cost approximately \$150 million. Professional personnel in hearing and speech requires three clinical audiologists, two audiometrists, two speech pathologists, and four speech and hearing therapists.

Where will we obtain personnel? There is no program in the State for the training of audiologists.

The needs provided in House Joint Resolution 494 is critically illustrated in the State of New Jersey. We have an immediate need for five audiologists and speech pathologists.

In 3 years we will need 25 more, and this does not consider the needs in the educational systems.

When you consider that the number 30 is small compared with the 400 graduates per year, but multiply the 30 by 50, and you find the figure is not small.

What about the homebound who can benefit from therapy and become productive, contributory members of society?

Facilities must be developed and expanded. This can only become a reality by the activation of H.R. 3465.

It is true that we need the facility, we need personnel, but we also need some means of obtaining economic returns for services rendered.

In New Jersey private agencies and the State department of health have taken measures to fill a need, but further expansion and development is required.

Thank you.

Mr. ELLIOTT. Thank you, Mr. Rickenberger.

Mr. Theodore Cohn, president, Occupational Center of Essex County, West Orange, N.J., is our next witness.

You may proceed, Mr. Cohn.

STATEMENT OF THEODORE COHN, PRESIDENT, OCCUPATIONAL CENTER OF ESSEX COUNTY, WEST ORANGE, N.J.

Mr. COHN. The few remarks I am going to make are also to be considered having been given by the Occupational Center of Hudson County, which is a comparable type of sheltered workshop.

First, we would like to indicate our support for the House bill 3465, the independent living bill, of which we are very much in favor.

I would like to add one point as to where we feel we would get a great deal of help or additional subsidization.

The sheltered workshop I represent deals primarily in the training and rehabilitation of cerebral palsy and mentally retarded adults. We are sponsored by several organizations and receive the bulk of our funds from the New Jersey Rehabilitation.

In addition to these two handicaps we also give help to epileptic people and we have had other handicapped, who our professional staff feels might benefit, come into the shop.

Now, the services of the rehabilitation, as far as support for our shop goes, continue for 40-odd weeks, during which time an extensive evaluation, guidance, and training program is given to the trainees.

At the end of this time it is often very difficult to determine whether or no a trainee is subject to vocational employment. In spite of the evaluation of both the rehabilitation, the sponsoring agencies, and our own staff give to such trainees, after the conclusion of this 40-odd

weeks of training, it is not always possible to place these people into employment.

I will say that the last week, as an example, we placed five people. Some of them had been in sheltered employment for as long as 5 months; some of them longer than that—as long as 2 years.

During this period, from the time they are training on the rehabilitation commission support has gone on. From that point on until they get employment, they are not sponsored by any State or Federal agency.

Because it is so difficult today to evaluate the period during which it is necessary to continue a person in sheltered employment before he can get private placement, we would like consideration to be given to subsidy for these people during the time that they are in what we call sheltered employment.

Now, the reason this is required is that the evaluative techniques which determine whether or not a cerebral handicapped person is capable of employment, have not yet been so refined that you can say a year before that person has finished his training he will be permanently employed in a private industry.

We cannot say that yet. Therefore, we have continued to take these people in our sheltered workshops even though at the end of this training period they have not gotten jobs, and have found, as our experience last week is an indication, that we can get them employment and take them off any other type of private or public support.

The amounts of money involved here are not very significant in relation to the types of training, but because the evaluation and the training period is so flexible, because the types of handicaps that the sheltered workshops deal with are so many, it is very difficult to cut that training period off at one point and then say at this point "No more" when we know from our own experience we have placed 20 or 30 or more people in private industry after their training period has been concluded because we have kept them in sheltered employment.

We would like, therefore, consideration for subsidization of this type of training in the sheltered workshops.

A second area we would like to have consideration for is the fact that sheltered workshops should be included in the group of organizations who have access to government surplus property by gift or by special purchase. Sheltered workshops are nonprofit organizations. They are usually locally sponsored. They do receive some funds from State rehabilitation commissions for their training.

But in their setting-up period, particularly where they have a large number of trainees before they have gotten a fair amount of public support in their community, they are usually in desperate need for basic facilities—desks, tools, equipment, supplies, and even buildings.

If sheltered workshops could be included in that group of organizations which has access to Government surplus property, it would be a great help.

Another point we would like to mention is the coordination on a national level of the type of work that sheltered workshop employees can do. What I mean by that is this:

Though there are professional organizations, they have not, to my knowledge, and the knowledge of our staff, developed this type of information. I will give you an example:

Our own workshop, dealing primarily in retarded and palsied people, does a great deal of contract work in the Essex County area with manufacturers and other types of business people. We know now from our own experience the type of work that our handicapped people can do. We have standards. We know how many items they can make, assemble, nail, and test.

If there were a national place to which all of this type of information could flow professionally, it would be a great help. It would mean that if we knew that a Kansas City sheltered workshop dealing in the retarded, for example, or in the epileptic, or in brain damage people, was capable of doing a specific job and had done so successfully and had developed standards for the type of work that its handicapped people could do, it would give us a confidence with information to go to a comparable manufacturer in Essex County and say we know that they can do this because a comparable workshop in Kansas City has done it and our people are the same level of handicap.

We feel this could be done on a national level because there are sheltered workshops all over the country and their experiences are not that diverse.

Most of them have fairly narrow areas of work and getting this information in one channel would be a great help.

Mr. ELLIOTT. Mr. Cohn, you have 1 minute now in which to finish. Believe me, it is hard to stop somebody who is talking about something as interesting as I consider your testimony to be, but that is the way it has to be.

Mr. COHN. One last statement, then.

We would like to have the Congress consider all handicapped, cerebral-palsy-handicapped people, in one category. Instead of putting the blind and the epileptic and palsied and retarded and narrowing them down, we have found as a multihandicapped shop that cerebral-handicapped people basically can be handled.

It is not crucial unless there are severe medical reasons or psychological reasons why all people cannot be put together if they are severely handicapped.

We feel that all cerebral-handicapped people should be considered in one category and that legislation should be determined for them.

Thank you.

Mr. ELLIOTT. Thank you very much.

Mr. Giaimo has a question.

Mr. GIAIMO. About putting the handicapped together, is that the consensus of thinking as far as the blind or some of these other handicapped?

Mr. COHN. I doubt very much, if I were representing the blind, whether I would want to have the interest of the blind diluted in effect by having them included. But we represent five or six different handicaps, some of whom are not organized to the same degree that the blind are.

From a human viewpoint, a cerebral-palsied person is just as disabled as the blind.

Mr. DANIELS. Your workshops have the necessary techniques and experts to take care of all of these handicapped?

Mr. COHN. The handicaps we have been able to accept in our particular workshop have been accepted only when the rehabilitation

commission and our professional staff feel we can take them. This group so far in our 5 or 6 years has included the retarded, palsied, brain damage, epileptic—we are not considering multiple sclerotic people.

Mr. ELLIOTT. Dr. Michael Marge, key coordinator, New Jersey Liaison Committee on American Speech and Hearing Association, Montclair, N.J.

Dr. Marge, you may proceed for 10 minutes.

STATEMENT OF DR. MICHAEL MARGE, KEY COORDINATOR, NEW JERSEY LIAISON COMMITTEE ON AMERICAN SPEECH AND HEARING ASSOCIATION, MONTCLAIR, N.J.

Dr. MARGE. Mr. Elliott and members of the committee, what I have to say today is being said on behalf of three facets of our population.

First, I speak for the key personnel in the area of speech and hearing pathology and of the education of the deaf who attended the New Jersey workshop on Federal legislation, which was recently held at Montclair State College.

Second, I represent that segment of the college and university teaching profession interested in the training of qualified professionals in the field of speech and hearing.

I am a college professor.

And, third, as a speech pathologist and member of the American Speech and Hearing Association, I wish to assume the privilege of representing the millions of individuals suffering from communicative disorders, such as the deaf, the aphasic, the cleft palate, the cerebral palsied, the stutterer, and the laryngectomized.

Those whom I represent strongly support the bill you have introduced, Mr. Elliott, House Joint Resolution 494, since it provides grants-in-aid to training institutions for the education and training of professional workers for the seriously understaffed area of special education, the speech handicapped and hearing impaired.

Seriousness of the communicative disorder: Undoubtedly, in past hearings, you have heard much testimony describing the incidence of speech and hearing handicaps in our population. But has the serious nature of the handicap been effectively communicated to you?

Without becoming maudlin, please let me describe three reasons why the communicative disorder presents one of the most disabling problems faced by the handicapped individual.

First, since speech and personality are so intricately related, many of our patients present concomitant problems of emotional illness.

Second, from your own experiences in the process of interacting with your associates and colleagues in Congress through the seemingly magical powers of oral communication, you must realize the tremendous need each human has for oral expression.

This avenue of communication is closed to the handicapped individuals with whom I work. The result is heartrending.

And, third, as one of the most serious of handicaps, communicative disorders also represent the largest number among those in need of special education.

Incidence in New Jersey: May we briefly turn now to a consideration of incidence. I must admit that I can best speak about the scene in New Jersey.

Using the New Jersey Department of Conservation and Economic Development, estimates of total population in the State, at present we find a population of about 5,900,000.

The American Speech and Hearing Association estimates that for the general population we will find 5 percent with speech handicaps, and 3 percent with hearing impairments severe enough to require the services of a speech pathologist and audiologist.

Therefore, in New Jersey we can expect to find 295,000 individuals with speech disorders, and 177,000 individuals with hearing disorders, giving us a total of 472,000 communicatively handicapped persons.

If we use the conservative prediction of the 1950 White House Conference that 5 percent of the school population can be expected to have speech and/or hearing handicaps, we find in New Jersey, 88,500 children between the ages of 5 and 19 with communicative disorders in need of special attention.

Incidence in the city of Bloomfield, N.J.: Let us consider for a moment what this means to a small community such as Bloomfield, the town in which I reside. Bloomfield has an estimated population of about 55,000; therefore, we can expect to find 2,750 speech handicapped and 1,650 hearing handicapped children and adults, giving us a total of 4,400.

The only trained personnel working in the city of Bloomfield are two speech therapists who have been hired by the board of education. If they were responsible for the total population of speech and hearing handicapped children alone, they would have to serve some 825 cases.

But what about the remaining 3,575 handicapped persons outside the age range of 5 to 19? They are left to shift for themselves—to search for help in areas far from home and at great expense.

In the area of education of the deaf, the need for trained personnel is equally as great. Recently, I received a communication from Miss Gladys Fish of the Bruce Street School for the Deaf in Newark. She indicated that 25 deaf children over the age of four had to be turned away this year because of a shortage of qualified personnel and lack of facilities at her school.

The estimates I have presented represent the population now, but we well know that our population is ever increasing and with this increase, the problem becomes more acute.

The need for personnel and training facilities: Using the estimate of the Office of Vocational Rehabilitation that there is the need for 1 speech pathologist and 1 audiologist per 50,000 population, providing a strong speech and hearing program is operating in the schools, in New Jersey we presently need 118 speech pathologists, giving us a total of 236 qualified professional workers.

We have—and I repeat—we have only eight individuals who may work independently at the level of advanced certification by ASHA with at least a Master of Arts degree.

Presently, there are no programs in the State for the training of speech pathologists and audiologists. However, there are at least four institutions of higher education prepared to inaugurate a training program on the graduate level for speech and hearing pathologists.

But money is sorely lacking.

Based on OVR experience of the past 2 years, \$11,000 per school per year would be needed to provide each of these training centers with additional staff and equipment to upgrade and expand training facilities. If this support were to be extended to provide training fellowships at the current average of OVR—which is \$2,500 per fellowship—and if Government support were to be provided for one-third of the needed 236 qualified personnel we must train each year, at least 195,000—78 persons at \$2,500—would be needed annually for traineeships.

The combined annual cost of the teaching grants to the 4 schools and training grants to trainees, would come to a total of \$239,000 per year for 10 years. Such grants would give us the necessary impetus to organize these programs as soon as possible and to train as well as possible the needed personal.

The need for House Joint Resolution 494, at the Frampton committee workshop in Philadelphia last Tuesday, a representative of the Pennsylvania State Bureau of Vocational Rehabilitation cited the fact:

That for every dollar the Office of Vocational Rehabilitation spends for the habilitation of the handicapped, seven is returned to the Federal Government.

In view of this, passage by Congress of House Joint Resolution 494 makes good money sense.

But we should not overlook the tremendous humanitarian values implicit in aiding the individual with communicative disorders. Let me illustrate:

Twenty seconds recording—speech of a young adult stutterer. I shall never forget this case of a stuttering boy of 19 who was refused admission into college because of his stuttering despite his high level of intelligence and his qualifications for success in every other respect.

In my experience as a speech pathologist, this situation has been repeated time and time again. In an age when we, as a Nation, are desperately trying to eliminate waste in manpower, to improve human communication in a growing democracy and in a dwindling world where speech becomes the core of human interaction and cooperation, and to ameliorate the lot of the handicapped child and adult, we must not overlook the question of providing qualified professional personnel to meet the needs of this grave situation.

I beg you to consider these matters and to call for an early hearing and passage of Mr. Elliott's legislation.

Let me thank you for this opportunity to express my views and the views of my colleagues in New Jersey about the importance of speedy consideration of House Joint Resolution 494.

We fully appreciate your kind interest in our behalf and sincerely hope that our efforts will not have been in vain.

(List of workshop and participants in New Jersey Workshop on Speech Pathology, Audiology, and Education of the Deaf, follows:)

PARTICIPANTS IN NEW JERSEY WORKSHOP ON SPEECH PATHOLOGY, AUDIOLOGY AND EDUCATION OF THE DEAF

Dr. Michael Marge, Chairman of Workshop, Assistant Professor of Speech, Montclair State College, Upper Montclair, N.J.

Dr. George W. Gens, Director, Special Education, Newark State College, Union, N.J.

The Reverend John P. Hourihan, 47 Central Avenue, Newark, N.J.
 Miss Betty Horwitz, Speech Pathologist, Kessler Institute, West Orange, N.J.
 Mrs. Eve Hubschman, Assistant Professor of Speech, Montclair State College, Upper Montclair, N.J.
 Miss Ellen Kaufmann, Associate Professor of Speech, Montclair State College, Upper Montclair, N.J.
 Mr. Donald Markle, Audiologist, 2345 Linwood Avenue, Coytesville, N.J.
 Mr. Herbert Rickenberg, Director, Speech and Hearing Services, Newark Eye and Ear Clinic, Newark, N.J.
 Dr. Jay Sanders, Speech and Hearing Center, Trenton State College, Trenton, N.J.
 Dr. Harold Scholl, Professor of Speech, Montclair State College, Montclair, N.J.
 Mr. Louis Stolia, Director, Speech and Hearing Services, Montclair Public Schools, Montclair, N.J.
 Mr. Anthony Suraci, Seton Hall University, Newark, N.J.
 Miss Jane E. Swartz, Speech Correctionist, Bloomfield Public Schools, Bloomfield, N.J.
 Miss Elizabeth F. Titworth, New Jersey School for the Deaf, West Trenton, N.J.
 Mr. Phil Wakstein, Speech Pathologist, Hospital Center at Orange, Orange, N.J.
 Albert L. Venutolo, 194 Sip Avenue, Jersey City, N.J.

Mr. ELLIOTT. Thank you very much, Dr. Marge.

Now, I recognize the gentleman from Connecticut, Mr. Giaimo, for a question.

Mr. GIAIMO. Dr. Marge, these figures you gave me about the 5 percent incidence in New Jersey and the lack, the almost total lack of numbers of trained personnel, is very similar to the situation in Connecticut and some of the other States.

But is there any indication that there are people who want to take this type of training?

Dr. MARGE. Yes, there is. We are training undergraduates presently. Most of them are having difficulty in seeking financial support on the graduate level within this area.

They will have to go to Midwest or California.

Mr. GIAIMO. I have heard this testimony before and I am very much interested in it. Yet, I wonder if the reason that many of the schools do not have this type of training is because there might not be a demand for it, rather than funds for it.

Dr. MARGE. There certainly is demand.

Mr. GIAIMO. Demand in the sense that there are students who want to study it?

Dr. MARGE. Yes, there is demand.

Mr. GIAIMO. There definitely are students who would like to take up this type of study?

Dr. MARGE. We can provide statistics if you wish.

Mr. GIAIMO. I wish you would.

Dr. MARGE. We will present the information to the committee.

Mr. QUIE. Have you appeared before your State legislature advocating that some program be started for the training of speech and hearing pathologists?

Dr. MARGE. I will say in deference to the State Department, we have tried for a number of years. There are a number of professionals in the eight—there are about eight of us who have tried and we have not been too successful at the present time because of the lack of funds.

We have a peculiar situation in New Jersey. It is unfortunate.

Mr. ELLIOTT. Thank you very much, Dr. Marge.

Dr. MARGE. Thank you, Mr. Chairman.

Mr. ELLIOTT. Now, I am going to turn the gavel over to my friend and coworker, Mr. Daniels, a member of this subcommittee. Mr. Daniels will preside over the hearings for the next hour. He will call the witnesses.

Mr. DANIELS (presiding). Mr. Chairman, I would like to present the next witness, a young man I have known personally for many years, and who has been very active in our civic and social societies in our State.

This young man is the director of the Jersey City Housing Authority and also a member of the board of governors of the New Jersey Citizens Council on Aging.

In connection with his association with both these organizations and civic and welfare societies in the city, he is very much interested in the problems of the aged and also the handicapped.

So it is my pleasure to present Mr. Conrad Vuocolo.

STATEMENT OF CONRAD VUOCOLO, DIRECTOR, JERSEY CITY HOUSING AUTHORITY, NEW JERSEY

Mr. VUOCOLO. Thank you.

Mr. DANIELS. Do you have a prepared statement?

Your prepared statement appears rather voluminous. I would suggest to you that you summarize it and I shall direct the reporter to file your prepared statement immediately following your oral testimony.

Mr. VUOCOLO. Thank you, sir.

I would not attempt to read the statement because of the time limitations, but I have a synopsis here which I will take about 4 or 5 minutes.

At the outset I would like to express appreciation to the Honorable Carl Elliott and to you, Congressman Daniels and other members of your group, for the opportunity to testify.

Many here in Hudson County are pleased that these hearings are being held. From my understanding it is the first time in the history of our county that hearings of this type are being held in this locale.

No doubt it is a tribute to our hard working Congressman, Congressman Daniels.

I like the provisions of your proposed bill and feel sure it will provide a renaissance of ideas and assistance to those we are discussing today.

For studying such problems and aiding these groups you are to be complimented for your strife to help those who so badly want to help themselves.

When the invitation to appear before your committee was received, we conducted a survey among our 3,500 families comprising about 16,000 persons.

This is our low income housing program of nine developments.

Much to our surprise more than 25 percent of those living in our units have persons in their family who are in the age category or afflicted with dystrophy, tuberculosis, chronic heart condition, deaf, blind, mentally retarded, the palsied.

While we were surprised at the high number, it justified the close relationships we have enjoyed with the city, county, and State agencies.

We work together here in Hudson County with these agencies in order to assure every possible assistance to be granted not only to those with low income families, but those who have special problems.

We present this in order that your group, or future working groups, with the same problem, may carefully consider the service that public housing in general can provide for those you are studying; namely, the privilege of homes at home, removing the necessity of institutionalization and furthering the independent living provisions of your bill.

Happily we can report that the housing authority just 10 days ago housed the first woman in the State and possibly in the Nation, who is a totally disabled person and under the recent change in the Federal Housing Act we were privileged to house her.

She was ready to go to an institution at the county level.

In the prepared report we indicated the story of the quadriplegic that we moved into our newest elevator apartment which permits him now to leave his former four-story walkup where he was virtually a prisoner for 8 years since the time he had his spine crushed.

Housing authority personnel in our desire to be of assistance have specially constructed movable ramps to assist the young man in question when he desires to leave the apartment.

To complete a picture of possible vocational rehabilitation in this case the New Jersey Commission on Rehabilitation has requested that we consider the man being able to obtain a degree of self-sufficiency by permitting him to have a newsstand or candy stand at the sight level.

Some of our developments are in areas where he could be providing the service and also providing his own keep.

In addition to some of these positive actions and there are more noted in the report, we offer several suggestions concerning medical care on sight for the aged and the possibility of removing the necessity of maintaining some of the senile patients in our county homes in mental hospitals to public housing units where they may have the dignity of their own home and at the same time reduce costs for expensive hospitalization.

This sounds very vague, but the housing authority with the cooperation of all the social and welfare agencies that would be necessary would be willing to try an experiment of taking two of the aged in the geriatric hospital, put them in the public housing, have your public nurses visit them on occasion, have the county welfare board provide assistance, we provide the housing. I think that program may not be novel, but we would like very much to try the experiment at our level.

Due to the large number of these cases we have within our units and no doubt other communities of our size have a like or larger number, we would like to present the possibility of a study to determine the feasibility of having one such housing development of special construction which would contain in specific amounts facilities for the blind, deaf, crippled, the aged, et cetera.

We could envisage such a unit that would be well termed a rehabilitation village which would necessarily, of course, have to be staffed with the medical, social, educational personnel and facilities who would provide the services on the site, itself.

At present a great amount of time and money is being expended to transport these people to schools, hospitals, and also treatment centers, sheltered workshops et cetera.

I am sure with the proper study a sheltered workshop could be put possibly on the site of the huge development and it would provide some income and assure the independent living aspects of your bill.

The combined function with special ramps, room layouts and other facilities are envisaged for those in need.

We can see where training or rehabilitation would be permitted on a 12-month basis.

Let me tell you, gentlemen, in closing, we work with families very closely. I have seen the effect of the implosion of a family that has all of a sudden gotten a problem where the child is determined to have cerebral palsy or a child is suddenly discovered to be deaf or you have the situation of an aged parent.

The effects are tremendous. That is why you really should be congratulated. I hope the provisions of the bill will be enacted because they are very, very necessary from our level and we only talk from one segment of a rehabilitation team, just the housing level.

But public housing in general, I think, are willing to try experiments to reduce the cost of institutionalization, to make homes for people where they belong at home.

Thank you.

Mr. DANIELS. Thank you, Mr. Vuocolo.

Are there any questions?

(The formal statement of Mr. Vuocolo follows:)

STATEMENT BY CONRAD J. VUOCOLO, DIRECTOR OF TENANT RELATIONS OF THE HOUSING AUTHORITY OF THE CITY OF JERSEY CITY, PAST PRESIDENT OF THE HUDSON COUNTY SOCIAL WORKERS' CLUB, AND MEMBER OF BOARD OF GOVERNORS OF THE NEW JERSEY CITIZENS' COUNCIL ON AGING

At the outset I would like to express appreciation to the Honorable Carl Elliott, chairman of this committee, and Congressman Dominick V. Daniels for the opportunity to testify regarding these hearings on needs for rehabilitation and special education.

No doubt this committee heard yesterday of the many negative situations regarding needs in the fields under study at these hearings.

While I will present some problems that may be able to be corrected, I would like to have the initial part of my statement reflect some of the positive actions taken at our community level regarding some of these problems.

1. It has been the policy of the housing authority of the city of Jersey City to work in very close contact with social and welfare agencies throughout the county to assure every possible assistance be granted not only to those low income families as such but those who have special problems regarding the aged, physically handicapped and others who are in need of rehabilitation. With this in mind I think I would be remiss if I did not have inserted into this official record due and adequate credit to the commissioners of the housing authority of the city of Jersey City, our governing body: Board Chairman Samuel C. Di Feo, Vice Chairman John J. Barry, and Commissioner Peter J. Murphy, Commissioner Maurice B. McLaughlin, Commissioner John C. O'Neil, and Commissioner John Ross, who have provided excellent decisions regarding our desire to house those in the greatest need for improved housing conditions.

As reported in the Jersey Journal of August 29, 1955, the housing authority in conjunction with the Jersey City Medical Center instituted a program of tak-

ing long-term ambulatory patients out of the hospital and placing them into public housing with the cooperation of the medical center officials, welfare and public health officials. We housed Mrs. Kay S. and her sister Mary, who are both muscular dystrophy victims. Mrs. S. was in the hospital for more than a year and required long and costly treatment which had to be provided by the community on an indigency basis. With all teams cooperating in this Operation Rehabilitation this family was housed and while one member of the family lost the fight to the disease, the other still remains in the dignity of her own home.

Many other cases of this type have been worked out reducing the long-term institutional care. As a matter of fact we are preparing to house a long-term tuberculosis patient at the request of the rehabilitation counselor of the B. S. Pollak Hospital for Chest Diseases, in a unit immediately adjacent to the hospital which will still permit necessary home or outpatient treatment.

2. In addition to working with our medical facilities on cases of this type, the Jersey City Housing Authority led the fight to remove the necessity of a family composition to be of two or more persons, allowing single elderly folks to be housed in low income housing units across the country at age 65.

This made unnecessary the admittance of many of these persons to institutions or homes provided for the aged. In September of last year President Eisenhower signed into law a reduction in the age, which now permits the housing of females at age 62 as a result of a bill which was sponsored by Congressman Cornelius E. Gallagher of Bayonne, N.J., at the specific request of the commissioners of the Jersey City Housing Authority.

We were very happy to house Mr. Mary Ford as the first woman in the Nation to be admitted under the new law. This action was reported in the December 1959 edition of *Aging*, the official publication of the U.S. Department of Health, Education, and Welfare, page 2, a copy of which is attached hereto and marked

We were very happy to house Mrs. Mary Ford as the first woman in the Nation

A second feature of the September 1959 changes to the housing law allowing the housing of persons totally and permanently disabled to be housed at age 50.

On February 4, 1960, we housed Mrs. Louis Lyles, a disabled widow, recipient of benefits for total disability from the Hudson County Welfare Board, into a unit of her own. This move was marked as the first in the State of New Jersey, and possibly the Nation, to be allowed.

For your information we are submitting herewith copies of articles appearing on this subject in the Newark News of Friday February 5, 1960, and also the Jersey Journal and Hudson Dispatch. (See exhibit B.)

In addition, the New York Journal American reported the admittance of this disabled widow which was hailed by Commissioner John W. Tramburg, director of the State of New Jersey Welfare Commission as of great social significance. This case illustrates where public housing was in a position to serve both the tenant and the community as the welfare board paid \$53 per month for this person who is now in one of our one-bedroom units at a \$28 welfare charge which includes heat, gas, and electricity, and refrigeration.

3. In addition, last August 27, 1959, in order to point up the cooperation necessary in order to completely rehabilitate whenever possible, housing accommodations were provided in an elevator apartment at the request of the New Jersey Rehabilitation Commission for Neil G., age 23, who had been bedridden since his spine was crushed 8 years ago in an automobile accident. Attached herewith are articles appearing in the August 27 edition of the Newark News and the Jersey Journal reporting the housing of this paraplegic. (See exhibit C.)

The part that public housing did play and could play in cases similar to this has had significance in view of the fact that the rehabilitation commission reported to us that the man was virtually a prisoner in his four-story walkup apartment which just about nullified the work provided by the New Jersey Rehabilitation Commission and the Kessler Institute at a cost of over \$30,000.

Miss Carmel Cucinotto whom we have worked with regarding this case certainly deserves our compliments in the excellent presentation and dignified persistence she pursued prior to the housing of Neil G. Please note in the articles attached hereto that the housing authority through its cooperative maintenance men set up special steel ramps permitting the tenant to enjoy outside freedom and use of recreational facilities at the Currie's Woods development where he resides.

In addition to working with the New Jersey Rehabilitation Commission we enjoy a close relationship with the New Jersey Commission for the Blind, and

the Veterans' Administration, and Social Security Administration, and the housing of many cases referred to us involve persons who are troubled.

4. Housing of the aged. The Jersey City Housing Authority and no doubt other housing authorities in urban areas such as those in Hudson County were faced with the problem of a steady disturbing shift in population.

This shift in population is resulting in an exodus to the suburbs of the youthful, economically safe, and healthier segment of our population.

In the 1950 census, Jersey City had over 30,000 of its citizens or over 11 percent in the age 60 or over category. It is anticipated that the 1960 census, soon underway, will result in a jump to 15 percent or 17 percent in this area.

The housing of this group provides many problems, especially in view of the fact that the Jersey City Housing Authority has no specific housing for the elderly. In order to provide therefor, the Commissioners of the Housing Authority of the city of Jersey City immediately earmarked \$60 of their 3,518 apartments for use by the elderly, and ordered preference for admittance whenever possible.

We have a population of about 2,000 of these so-called senior citizens who would possibly be forced into some medical or old-age institution had not these units become available wherein rents are charged commensurably to their incomes.

We do, however, have over 1,000 applicants on file and are requesting approximately 300 units to be specifically designed for the aged.

In addition to the above, we are most happy to report that several months ago we were able to house several of the residents of Sienna Hall, a resident home for the aged who were forced to move when the residence had to close due to economic reasons. (See report of March 17, 1959, attached and marked "Exhibit D".)

It is with this picture in mind that Mr. Jim Bishop, the nationally syndicated columnist of the *Journal American*, reported in his column of July 16, 1959, that an aged couple whom he has befriended indicated that the public housing unit they resided in could be termed " * * * home for the ruptured and crippled * * *."

In view of the following we have often heard that our public housing units could reflect part of the famous quotation " * * * give me your tired, your poor, your huddled masses yearning to breathe free, the wretched refuse of your teeming shore, send these, the homeless, tempest tossed, to me, I lift my lamp beside the golden door," which is on the base of the statue of our fair lady standing on Liberty Island in New York Harbor for the last 75 years.

Some of the other features we have put into effect regarding service to those involved are the following:

(1) Senior Citizens Employment Service, wherein local employers have cooperated and provided part-time "special situation" employment to our senior citizens and helped project the desire for independent living. Kindly see the attached account from the March 1, 1959, edition of the *Newark News* reporting the housing of Mrs. Pauline Stager, age 94, who requested a specific location because she wanted to be near her work, and from the *Jersey Journal* of September 29, 1959. (Exhibit E.)

(2) A public information center. We have created for each one of our nine developments public information centers which we stock with many fine booklets provided by the U.S. Government Printing Office on subjects regarding nutrition, health, medical care, etc. Congressman Dominick V. Daniels has been of assistance in obtaining these booklets for distribution.

(3) Senior Citizens Information Center. Staffed by personnel of our agency. In addition to their other duties, provides information regarding health, educational, and other community agencies who handle the problems of the elderly.

While the above illustrates some of the positive results that adequate or public housing can play in the problems of the handicapped, we would like to respectfully recommend the following action be considered regarding the aged and infirm and possibly some of the other areas under consideration by this honorable committee.

(1) As we have a high concentration of the elderly folks in our developments, the housing authority has been attempting for the past year to have the community, possibly with the assistance of the Seton Hall Medical College, located here in Jersey City, provide traveling geriatrics clinics. This type of service we feel can be easily furnished by utilization of facilities existing in each of our units known as baby "Keep Well" stations. With this view in mind discussions

were had last week with the staff at the college regarding this possibility. Your committee may be of service in possibly arranging that Federal, State, or private agency provide grants and aid for health service or funds to permit medical schools and universities to develop programs for the teaching of basic concepts to the care of the aged.

No doubt the low-income families who are now denied medical care or service⁺ would provide excellent training programs for those pursuing courses of study in medicine or rehabilitation.

Fuller utilization possibly of facilities of the Public Health Service may result in the increased care on a preventative basis which would nullify or reduce the terrific burden communities have in providing hospital or institutional care for the aged.

(2) Income maintenance is of the utmost importance as we have witnessed countless members of tenants or applicants for our units in severe emotional states "driven out of their minds because they cannot carry on with the meager income provided by welfare or social security benefits."

Realistic public assistance payments, we believe would give many of these persons the strength to carry on and remove the necessity for many of them turning into homes for the aged resulting in high institutional costs.

With this in mind we recommended last July 1959 to Congressman Dominick V. Daniels and Congressman Cornelius E. Gallagher that they urge the Government to study the possibility of obtaining surplus foods from agencies such as the Department of Agriculture for distribution to the elderly low-income persons needing the same. We have requested that the food be distributed in such a manner that would uphold the dignity of the individual involved, perhaps through a stamp plan.

Many are puzzled when we read of the millions of dollars in food and aid being sent to foreign lands when some of our own citizens are being forced to try to suffice on \$40 or \$50 per month.

Perhaps your committee would like to pursue this possibility as to see whether such a food plan is feasible.

It has been noted in the report on Conference on Economic Progress, December 1959, on the Federal budget and general welfare that the income position for the senior citizen is dismal. They report that, "It follows that most of these old people do not have the means to maintain even a minimum standard of health and decency."

We note this daily in our developments and it appears that some of our aged tenants seem to be wasting away from malnutrition. In our opinion there is nothing like adequate food to eliminate cases of mental or physical breakdown among our elders, making necessary institutional or hospital care cost tremendously.

We also would like to recommend that a study be made of the possibility of extending the purpose of the school lunch program to provide for the feeding of these elderly low income folks in existing school facilities at nominal cost to them. As the facilities would be in use for most of the year for the school-children who are fed with some of the surplus foods provided, we feel that the extension of the service to include the elderly would cause slight inconvenience.

(4) Recreational and social needs. Recreation is an important facet of serving this group of citizens who certainly deserve consideration for the great contributions they have made to our country financially and in time of war.

It is very difficult to provide recreation facilities in communities such as ours without adding overburdening costs to the local government.

Perhaps grants can be made to recreational or educational departments of communities to train or provide service or community recreational centers for use by the senior citizens.

Last weekend we had a most unfortunate incident concerning one of our 80-year-old tenants who fell in her bathtub on Friday evening and was not discovered until the following Tuesday. Situations like these point up the need for a coordination of all services recommended if we are to avoid undue hardship as illustrated for our aged and/or chronically ill. The assistance required to provide for the services and counseling necessary for developments like ours where there are high concentrations of citizens in the categories under study should come from a Federal level.

(5) Housing of institutionalized. Finally, we would like your committee to consider the urging of the medical facilities involved to consider the housing

of many patients in the geriatrics hospitals into adequate housing as public housing can provide.

We have recommended to the Hudson County Freeholder Board that they consider the possibility of releasing some of their patients, possibly even two unrelated persons whose admission is now permitted under the law to public housing units.

We feel that accommodations in units such as ours would (1) provide the dignity of a home; and (2) reduce the cost of maintenance of such patients in the county hospital.

It is my understanding that the cost of caring for a patient in a hospital is \$190 per month, or \$380 for the maintenance of two persons who could be maintained in a public housing unit at perhaps a combined outlay of about \$200 for food, shelter, and clothing, provided through the welfare board charged with their needs.

Regarding this point we quote from page 15 of the New Jersey Commission To Study the Department of Institutions and Agencies, 1959 report on organization for social welfare, under programs for old people:

"No one who has visited the senile wards of a State hospital can fail to form the opinion that many of these older patients are not changed, but have simply become incapable of sustaining day-to-day existence in close quarters with normally active people, and of meeting the complex demands of the modern rapid-fire world in which most of us live. Their needs are very different from those of patients suffering from acute mental disturbances. Often their physical infirmities are as distressing as their mental peculiarities, and may be confused with them. Too often they are denied the comforts of old age, of which they need not be deprived when the proper environmental aids are made available to them.

"If large numbers of our seniles could be moved out of permanent residence in the State hospitals and provided with day care, transportation to and from home, and medical attention specially designed for their needs as they gradually deteriorate with age, we should find, as others have found, that they can live out their lives in dignity and in freedom. This would also free the State hospital beds, which they were destined to occupy for years on end, for the acutely ill."

We hope our request will be favorably considered as we feel certain that with cooperation on all levels public housing can again demonstrate their desire to aid.

A minor point, but perhaps an important one can be that it be a requirement that a citizens' committee be at work in each county if assistance from a Federal level is to be granted.

One of the requirements of the urban renewal program is that such citizens' committee composed of various groups be operating before grants are made for building funds. If such a committee is required on a Federal basis to build or rebuild cities, I believe a same type group should be required to help build or rebuild lives. In this manner committees such as yours could get a combined picture of the needs from such a central committee which would also assure fullest utilization of all community facets available to those who need rehabilitation.

I know here in Hudson County no coordinated council of social agencies is in operation which would serve as a clearinghouse for subjects under study by your group.

In closing, however, I would like to make known my feelings that the prestige of your subcommittee conducting hearings here in our county may act to stimulate the renaissance in the working objective of coordinated welfare activities.

Your group is to be congratulated for the tremendous task of conducting these hearings in deciding the merits of recommendations made.

I have witnessed on many occasions the effects of an implosion upon the family when they are struck or confronted with some of the problems you have under study today. Many who I have talked to have found some comfort in the last week when they read that these hearings are being conducted. One of those who I have spoken to is our friend "Neil G." who we in housing are attempting to aid further by permitting him to have a candy and newsstand in our new 712 apartment Currie's Woods development. The New Jersey Rehabilitation Commission is requesting such permission under its vocational rehabilitation program as this youngster has such a strong desire to be on his own, despite the handicap of being a quadruplegic.

For studying such problems and aiding and encouraging the handicapped you are to be complimented. You are striving to help those who want so badly to help themselves.

Mr. DANIELS. Our next witness is Miss Agnes Thompson, principal, A. Harry Moore School, Jersey City.

We have quite a number of witnesses scheduled to testify today. If we are going to get through here at a reasonable hour this afternoon, it will be necessary to limit the testimony of the witnesses.

If you have a prepared statement, you may submit it to our reporter.

I may suggest that you summarize the contents of your statement and your prepared statement will be filed in the record following your oral testimony.

However, you may proceed in any manner you see fit, but I must limit your testimony to 10 minutes.

Miss Thompson, you may proceed.

STATEMENT OF AGNES THOMPSON, PRINCIPAL, A. HARRY MOORE SCHOOL, JERSEY CITY, N.J.

Miss THOMPSON. I don't think I will take more than three.

I am here, first of all, not as a financier, not as a legislator, so I don't know what to tell you about what I think should be done, but I will tell you what our situation is, what we think our needs are.

I have jotted down on some cards some pertinent facts, but I do not have a prepared statement.

You may go into a normal public school of so-called average children and certainly not find what we need. We need therapists.

The other day at Philadelphia I noted one person said, "I can use five"; another person said, "I can use five." I said, "We can use three."

The people in charge of therapy schools are talking about you do have the dearth of personnel in your schools. They think you people do a good job on recruiting personnel.

I got very practical. I said I thought if you paid them a decent salary you would get the personnel. They are requiring physical therapists to have a college degree from the college of physical or occupational therapy, yet they start at \$4,000. This is rather ridiculous for highly trained personnel.

Mr. ELLIOTT. May I ask this question, Miss Thompson: How long do you have to go to school in the therapy field after you have your college degree?

Miss THOMPSON. It is approximately 2 years in the school. New Jersey requires that we have registered therapists for school physical therapists and occupational therapists.

Mr. ELLIOTT. Do you think that if salaries were higher, you would automatically get plenty of therapists?

Miss THOMPSON. I think you would be able to get them and keep them. I know we have lost one in our school because he went to another system where they have their therapists on the same salary schedule as the teachers.

I know we lost another because he can make more in private referrals from other doctors.

We had a candidate, she would not think of taking it because she is in one of the large New York hospitals where she gets private patients after they are discharged from the hospitals.

So our salaries in the institutions must be higher in order for us to keep a highly trained professional staff.

MR. DANIELS. What do you feel would be a fair and reasonable salary in this area?

MISS THOMPSON. I advocate, because they have training, educational requirements commensurate with the salaries, that they be put on the teachers' salary schedule when they have comparable training.

There is a need too in our schools for medical attendants because with the exceptional child a person must take the braces off.

We have many children who must be fed. During the schooldays the medical attendants feed the children, remove braces, take care of their toilet care, dress them and so on.

Of course, another thing which makes the course in special education much higher is the fact that we must have smaller classes.

I recall on one occasion saying to a director of special education, "I think that teaching three average children is similar to teaching one cerebral palsy."

He corrected me and said, "I think the ratio, Miss Thompson, is 4 to 1." In addition to the fact that our classes must be smaller, we have a slight extra compensation that we in Jersey City pay to the teachers in our special education program.

Some who spoke the other day in Philadelphia about status, I think if that could be arranged, if they could get a little extra compensation for the extra training that is required because they are required to have special education training in addition to their teacher's certificate, I think that that would give the status.

I am proud enough to think that we in Jersey City do have status, those of us who are affiliated with our special education program.

Because the multiple handicaps are frequently associated with cerebral palsy you must frequently take a child and instruct him individually.

I recall in my teaching days having a child with cerebral palsy who had never spoken a word because she had never heard the word. We first had to train her in the use of a hearing aid and gradually her vocabulary was built up.

There is a study in New Jersey by Dr. Hopkins, the former principal of the A. Harry Moore School; Dr. Byess, who is now the consultant for the Crippled Children's Commission, and Miss Carlton, former teacher in the A. Harry Moore School. They made a study of 1,000 cases in the New Jersey files and of the children in the A. Harry Moore School. I have a copy of that study here if you would like to have it. It will point up the need for special education in those places.

I have jotted down a few items that we need in educating and rehabilitating these children.

For instance, a wheelchair costs approximately \$150.

Knowing that I was coming here this morning, as I walked out the front door yesterday afternoon of the school, I looked around there, and I said there is about \$4,000 in wheelchairs standing there ready for the children to come in this morning.

Ear training equipment is approximately 300.

Electric typewriters: Some of the cerebral palsy cannot write; some can use the standard typewriter; others do not have sufficient strength so they must use electric typewriters.

Parallel bars to teach them to walk, safety training steps: It is a very easy matter for a child to walk up and down the steps. Here we have to spend \$260 to get these steps to train these children on so that they can learn that very necessary thing.

There are a number of tables to teach the children to feed themselves, to button themselves, and again I started by saying I was not a financier; I think that the Federal Government could and should assist any agency conducting such a program of education for the special children.

As I think of it, I think they might reimburse the agency who has that program by giving them a percentage of the excess cost of educating these children.

Now, I do not think we are asking really a favor there, because when we educate these children they become self-sustaining members of society. They are not age burdened, they do not have to be placed in institutions.

In most instances they are not collecting the social security that is given for a dependent child of a retired social security worker.

Again I have jotted down some of the occupations in which we find our graduates. I think of one who took mechanical dentistry training while a member of our school. He today owns his own laboratory and employs some of the members of our school, as well as others, one of whom I hear is earning \$165 a week.

The cerebral palsied, and we emphasize them because they are the greatest, I think, educational problem facing us, we had 83 graduates between 1936 and 1957. Of that number, 43 were working at the time this was done in 1957; 18 were still in high school and colleges; 4 were married women who did not go to work, 2 received rehabilitation training, 12 were homebound, and 1 was in a mental hospital.

I think that is a small percentage because I think the training they have received has made them successful and as a result they do not have the frustrations and the emotional problems that would ordinarily go with that disease.

Among our graduates we number commercial artists, insurance adjusters, IBM operators, accountants, designers, physicians, chemists, chemical engineering, teachers, pharmacists, and various skills, office and unskilled workers.

I don't know whether I have answered any of the things you want to know. I think we could use a greater therapy program.

I think that the Federal Government might consider reimbursing us. I think I have pointed out that those people are paying income taxes.

The Veterans' Administration has figures on that several years ago of how the person who was rehabilitated, a veteran, in a short time repaid in income tax the money that had been spent on him.

We like to believe that we are doing something similar.

Mr. DANIELS. Thank you, Miss Thompson.

Are there any questions?

Miss Thompson, in the course of your testimony you referred to a study made by Dr. Hopkins, former principal of the A. Harry Moore School.

Miss THOMPSON. Yes.

Mr. DANIELS. Do you desire to file that with the committee?

Miss THOMPSON. Yes.

Mr. DANIELS. Without objection, that may be done.

Miss THOMPSON. I also have here a booklet which is not up to date. It is a 1943 booklet, but it shows you many of the facilities of the A. Harry Moore School.

Would you like me to leave that?

Mr. DANIELS. You may leave that for our study.

Thank you very much, Miss Thompson.

Miss THOMPSON. Thank you, sir.

Mr. DANIELS. Our next witness is Dr. Henry H. Kessler, Newark, N.J.

Dr. Kessler, are you the famous Dr. Kessler of the Kessler Institute?

STATEMENT OF DR. HENRY H. KESSLER, NEWARK, N.J.

Dr. KESSLER. I am Dr. Kessler of the institute. I do not know how famous I am. I have the dubious distinction of having been in the field for 40 years.

Mr. DANIELS. We are honored by your presence.

Dr. KESSLER. You are welcome.

The older I get the less I know. However, I have followed the evolution of the care and education of crippled children and physically handicapped people for the past 40 years and it is a beautiful story to see how government and community agencies have worked together to solve some of the problems.

Originally, of course, the only services rendered physically handicapped men, women, and children were in the field of asylum and care, but today we see that constructive efforts in the field of attempting to make these individuals self-supporting members of the community have borne fruit.

There are still many gaps. There are certain special fields in which I am particularly interested and perhaps I had best confine my remarks to those one or two small areas.

I am referring to the children born without limbs. So-called congenital amputations, and children who have certain congenital defects of the cord known as spinal hemiplegia. This is a condition where lower extremities are paralyzed and the children have no control over bowel and bladder.

They are similar to adult paraplegics, but they are a group of children that have been overlooked for long periods of time.

Now, the problems involved are both problems for the child and problems for the parent. The mother will come to me with a child born without arms and legs as a doctor, "Why did this happen to me? What sin did I commit to make me the victim of this horrible catastrophe?"

I will try to reassure her and say this was no sin, this was a biological accident. It is just as much an accident as walking across the street and getting struck by an automobile.

They say, "What can you do for my child?"

I throw up my hands and say, "I don't know. I have been in this work for many years, but I have never had this experience. There is nothing in the books to tell me what to do."

But I said, "I am learning every day, from other similar disabled individuals, how to meet those problems."

Here, for example, is a man, an adult paraplegic, who has lost both legs at the same time. You watch him.

She was able to see how this man could get into his own artificial legs without assistance; get up from the floor with his own crutches, and walk up and down a short flight of stairs.

Then she said to me, "What will I do about arms?"

We were able to demonstrate to her a man and a woman with an arm off at the shoulder in whom we had utilized the chest muscle, made a channel or canal through it and attached an artificial arm.

Finally she said to me, "Doctor, shall I have any more children?"

"Well," I said, "medically the odds are against you. Theoretically if you were to have eight children one out of every eight will be born with a physical handicap." One of the mothers in the room said, "Doctor, I think I can answer that question better than you can."

"What do you mean?"

"I was faced with that problem 15 years ago when my daughter was born without a hand. I have had three children since; they are perfectly all right. I would say to that mother, you go ahead and have children."

She had a second child, a perfectly normal child.

These are the problems of anguish and despair that face the mothers unless they know there is some hope for their child. That hope can only be realized by the establishment of facilities where the severely disabled children can be taken care of and those facilities are available today throughout the country in the form of rehabilitation centers.

Rehabilitation centers provide not only medical services, but they are facilities for providing really special education, special education not only in the academic field, but particularly in the field of self-help and personal independence.

The important thing is to make these individuals independent and not requiring any assistance from their parents. So we teach these children, adults, others, how to take care of themselves, teach them the pursuits of life or activities of today, day to day living.

Similarly the child born with congenital deformity of the spinal cord requires a long system of training, special education, if you please, to take care of themselves to learn how to walk with crutches, to get on and off buses, how to meet the problems that everyone meets in the routine pursuits of life.

There are more than 77 accredited, well-developed rehabilitation centers throughout the country, but they are all struggling, they are all struggling with the problems of personnel, but primarily problems of finance to keep going.

Very few of them get any subsidies from either State or Federal agencies.

The Federal Government might very well direct its attention toward providing assistance to these well-qualified and certified agencies who are carrying on a program under great difficulty, but a program that cannot be carried out in any other way.

It is true that the State government, the county government, provides some financial assistance, but the administrative problems involved in providing assistance sometimes militate against the ultimate rehabilitation of the child or the adolescent.

The budgetary restrictions, administrative regulations, the problems with the cerebral disabled are so great that it frequently makes it difficult for an administrator or a civil servant to undertake these gargantuan problems when there are other problems of a less difficult nature that demand his attention.

Now my point, therefore, is to suggest and submit to you the importance of giving aid to these rehabilitation centers who have taken upon themselves this responsibility for taking care of the needs of these severely disabled—a congenital amputee, spinal hemiplegia, the cerebral palsy.

Mr. DANIELS. Thank you very much, Doctor. I had the privilege of visiting your institute. You have a very unusual setup. I have heard many fine complimentary stories about the institute you operate.

I want to thank you for coming here today to give us the benefit of your views. Thank you very much.

Dr. KESSLER. Thank you very much.

Mr. GLAIMO. Doctor, can you make a suggestion to us as to how we can get more interest on the part of many States so that they will begin to subsidize some of these agencies that need help?

Dr. KESSLER. For 40 years we have been carrying on a program of education—education of the man in the street, public citizens, employers—but our problem has been a problem of overcoming prejudice.

The man in the street regards a crippled child or a crippled adult as in league with the devil, with sin, malignantly or evil spirits.

This is a sad commentary on civilization, but apparently we have not progressed much since the day 2,000 years ago when the child born with a cleft palate or club foot was thrown over the cliffs by the Spartans.

Two years ago in south Africa I spoke to tribesmen that happened to have a crippled child born in their tribe. They tie the child to a goat, they tie the goat to a stake, and leave them both out in the wilderness for animals to consume.

Here we have 2,000 years of education and development and cultural improvement, but we still use aphadistic and primitive attitudes in prescribing the needs of these children.

It is for that reason we find employers unwilling to hire handicapped people. They will rationalize this prejudice. They say, "I would like to hire this man, but I am afraid he cannot do a good day's work; I am afraid that he is accident prone; I am afraid that the insurance company will raise my premium."

What they really mean to say is, "I hate to have a cripple around."

I have been in this work for 40 years trying to spread the gospel here and all over the world and then this happened to me. My son was in England learning how to make artificial limbs. He wrote home, "Dear Dad, dear Mother; I have found a girl I want to marry. She is an amputee."

My friend said, "Look here, Henry, aren't you carrying this a little bit too far? You are not going to approve, are you? Haven't you done enough for cripples of the world without bringing them into your own home?"

My wife and I were in a spot. We went to England and saw this girl and we fell in love with her. I said to my son, "Jerry, if you don't marry her, I will."

They are married today and she has given me two beautiful dividends in the form of grandchildren.

Primarily there is a deep monstrous prejudice responsible for this apathy and indifference. I hate to inject at this time a little poetic reference, but there was a Polish poet who said:

Fear not your enemies for they can only kill you.

Trust not your friends for they will only betray you.

But worse than death, and worse than betrayal, is indifference.

And this is a disease that unfortunately our body politic is suffering from.

Mr. DANIELS. Are there any questions?

Mr. ELLIOTT. I would like to compliment Dr. Kessler on his testimony, and to compliment more deeply and sincerely for the fine work that he is doing at the Kessler Institute. I think his accomplishments there are wonderful. I think he has demonstrated in his testimony the spirit which animates his endeavor at Kessler and makes it live and have meaning in our generation.

Dr. KESSLER. Thank you very much, but there are 77 other rehabilitation centers in this country. They all need help.

Mr. DANIELS. Thank you very kindly.

Our next witness is Walter R. Cohn, president of the Jewish Vocational Service, Newark, N.J.

Mr. Cohn, I understand that associated with you in your presentation today is the Honorable Harold Ackerman, chairman of the legislative and legal committee.

Are both of you going to testify?

STATEMENT OF WALTER R. COHN, PRESIDENT, JEWISH VOCATIONAL SERVICE, NEWARK, N.J.

Mr. COHN. No, I am just going to testify, but I brought Mr. Ackerman in case there are any questions.

Mr. ELLIOTT. Both of you have been allocated a period of 10 minutes. I must hold you to that rule because of the limitation of time.

Mr. COHN. It is difficult to follow a man like Dr. Kessler in testifying on a subject such as this, but I will try.

I am president of the board of trustees of the Jewish Vocational Service of Essex County. I have with me Judge Harold Ackerman, of the workmen's compensation court of the State of New Jersey, a member of the board of trustees.

This agency, the Jewish Vocational Service of Essex County, has been rendering employment, counseling, and rehabilitation services to the Essex County community for the past 20 years; since 1947 we have given special emphasis in services to the handicapped and those people with special problems.

During this latter period over 10,000 clients have been served by the agency, 8,000 in connection with employment, with over 3,000 placed on jobs.

Of these numbers, 80 percent served have been handicapped individuals, those with special problems and of those placed, 90 percent were handicapped.

The agency operates in four general spheres of operation, job placement, vocational counseling, psychological services, and we run a rehabilitation workshop.

This workshop originally was formed for the purpose of serving handicapped people. The emphasis has changed in the last few years to serve those who can be rehabilitated.

We have changed our policy not through desire so much as through necessity and want.

Our census at the present time runs between 28 and 30 people. This, again, is not because of need, but because of economic limitation. We have an agreement with the New Jersey Rehabilitation Commission which was signed in 1957 which makes our workshop a nonsectarian agency and which permits us to offer evaluation and rehabilitation services through the program.

We give special emphasis to people with emotionally handicapped problems. Recently in June of 1959 our agency was awarded a research grant of approximately \$20,000 over a 3-year period by the U.S. Government through the U.S. Office of Vocational Rehabilitation to study the effectiveness of the rehabilitation workshop and the rehabilitation program of psychiatric patients released from mental hospitals.

We are presently engaged in a study of the use of the workshop on the schizophrenic patient. We are doing this in a joint program with the Essex County Hospital.

We are also in agreement, a written agreement, with the Veterans' Administration locally whereby we give service to the patients of the Veterans' Administration after they leave the hospital.

Now I cite these brief facts in order to give you a background of our agency and to establish the fact that over the past many years we have a specialized experience in dealing with rehabilitation problems with the severely handicapped.

We have examined the bill, H.R. 3465, closely and I appear here today to express our conviction that this bill should be passed and passed as soon as possible. This bill will fill a much needed gap in the existing Federal legislation and will help assure us that there is a well-rounded and comprehensive program of rehabilitation services to the handicapped people of our country.

I will make some brief observations with regard to the specific provisions of the bill.

With respect to the evaluation services as provided for in the proposed bill, I would like to observe that over the past 7 years our workshop has been doing this type of work with potentially rehabilitatable people who are handicapped with a variety of disabilities.

We are limited, of course, because of the fact that we must use as subjects of our program people who are rehabilitatable. This limits us so severely that we cannot take care of thousands and thousands of people who would be potentially useful to the community if we were able to give services to them, not toward the design especially of rehabilitation to industry, but to rehabilitation to themselves, to the community.

We feel this proposed bill would permit us to do that.

In the present bill, extending this diagnostic service that we are presently giving to our subjects and to our clients would permit us to extend the program to severely handicapped people who are both institutionalized and are homebound and would increase the number of individuals who could be evaluated with the eventual hope and

knowledge that we could rehabilitate these people back to society to serve useful purposes.

The bill would also create a centralized agency for information which we feel most essential under the present conditions.

A second major provision that we are heartily in favor of is the provision that would rectify the situation where service is now denied to people who are not able to be rehabilitated through vocational rehabilitation. Our own program has convinced us conclusively that many severely handicapped individuals could be rehabilitated although they could not be immediately rehabilitated to employment. They could gain employment in a sheltered setting either within an institution or within a sheltered workshop.

The funds that this bill would provide would go a long way toward helping us in completing our program to give such service to people who could not be immediately rehabilitated to the industry, but could be rehabilitated to the community.

In our case experience we find that the disabled groups who would benefit from this extension of service would include the mentally ill, the mentally retarded, the cardiac, hemiplegics, aged, and socially maladjusted.

Another provision of the bill which we are heartily in favor of, of course, is the extension of the rehabilitation services through workshops and rehabilitation facilities. Our own workshop has during the past 7 years demonstrated the need for a long term and a terminal workshop.

Our original experience with the workshop was that we would emphasize the long term, the terminal case, the one that could not be rehabilitated, the one that could gain some self-respect by employment, although they could not get it in industry.

We, as I say, have had to limit our sphere of activities in this particular phase of rehabilitation because of limitation of funds. The passage of this bill, we know, would enable us to go back to what we feel a most necessary and vital need in the community, the rehabilitation of people in a terminal workshop where they could not be immediately employed in industry and where the emphasis was not rehabilitation for industry as such.

Our specialized experience with the psychiatric patient convinces us that this bill would permit the extension of funds so that we could complete what we hope would be the results to be gotten from the study we are now making as a result of our grant from the U.S. Government.

The rehabilitation program which now is geared for a short period of time in our workshop, 1 year or less, depending on the patient, could be extended so that the psychiatric patient, the emotionally handicapped and such persons as the cardiac, could be rehabilitated over a long-term program as well as the terminal case.

We would like to recommend also the establishment of sheltered workshops and institutionalized settings, such as hospitals and homes for the aged and convalescent homes.

In the past few months we have had requests from the home for the aged of Essex County to have a workshop set up in their institution. We feel that the passage of H.R. 3465 would implement greatly the work we are now doing and we strongly advocate its passage.

Mr. ELLIOTT. Thank you.

Do you desire to file a statement?

Mr. COHN. I have a statement to file which extends my remarks and gives case histories to back up the points I have made.

Mr. ELLIOTT. Without objection, your written statement will follow your testimony.

Mr. COHN. Thank you.

(The statement referred to follows:)

JEWISH VOCATIONAL SERVICE,
February 19, 1960.

CARL ELLIOTT,

Chairman, Subcommittee on Special Education, Committee on Education and Labor, Congress of the United States, House of Representatives, Washington, D.C.

DEAR MR. ELLIOTT: On behalf of the Jewish Vocational Service of Essex County, I am submitting for the record testimony in support of H.R. 3465, the Rehabilitation Act of 1959.

The Jewish Vocational Service of Essex County has been rendering employment, counseling, and rehabilitation services to the Essex County community for the past 20 years. Since 1947 it has given special emphasis in its services to the handicapped and those with special problems. During this latter period over 10,000 clients have been served by the agency, 8,000 in connection with employment, with over 3,000 placed on jobs. Of these numbers, over 80 percent served have been handicapped individuals or those with special problems, and, of those placed, 90 percent were handicapped.

Since 1957 the agency has been working in close cooperation with the New Jersey Rehabilitation Commission and has offered evaluation and rehabilitation services through its opportunity workshop program (a diagnostic rehabilitative workshop) with special emphasis on services to the emotionally handicapped.

More recently, as of June 1, 1959, the agency was awarded a research grant of approximately \$90,000 over a 3-year period by the U.S. Office of Vocational Rehabilitation, to study the effectiveness of a rehabilitation workshop in the vocational rehabilitation of psychiatric patients recently released from a mental hospital. This is a joint cooperative program with the New Jersey Rehabilitation Commission and the Essex County Overbrook Hospital.

I cite these brief facts about the agency in order to establish its specialized experience over a long period of time in dealing with the vocational rehabilitation problems of the severely handicapped.

After close examination and careful study of the proposed bill, H.R. 3465, we are convinced that, if adopted, it will go a long way toward filling a much-needed gap in existing Federal legislation and will help assure a well-rounded and comprehensive program of rehabilitation services to the Nation's handicapped citizens.

I should like to make some observations with respect to specific provisions of the bill:

TITLE I. EVALUATION SERVICES

Over the past 7 years our rehabilitation workshop, the Opportunity Workshop, has been doing evaluation and diagnosis of the vocational rehabilitation potential of handicapped individuals with a variety of disabilities. In this connection we have noted that, as our experience in this phase of work has increased, we have been able to deal with more severely handicapped individuals who in the past might have been considered too disabled to be helped by our services. (See case I attached.)

The present bill, by extending diagnostic services to the severely handicapped in both institutionalized and homebound settings, would thereby greatly increase the numbers of these individuals who could be evaluated, made more self-sufficient, and ultimately be rehabilitated.

If we interpret the provisions of the bill correctly, it will also serve to centralize the evaluation and referral process in our respective communities and eliminate some confusion and weakness which presently exists in this area.

TITLE II. INDEPENDENTLY LIVING REHABILITATION SERVICES

The second major provision of the bill would help rectify the situation where denial of service is now the case for many individuals who could secure substantial benefits from rehabilitation and who may eventually even prove themselves to be capable of vocational rehabilitation. Experience in our own program has proved conclusively to us that many severely handicapped individuals who may not be immediately capable of returning to remunerative employment can still be helped considerably to improve in their functioning capacity and may even ultimately be able to sustain employment in a sheltered setting, either within an institution or in a sheltered workshop in the community.

From our case experience, among the disabled groups that would benefit by this extension of service are the mentally ill, mentally retarded, cardiac, hemiplegic, orthopedic, aged, and socially maladjusted. Extension of independent living rehabilitation services to the institutionalized and homebound would result in improving the condition of a great many such individuals and ultimately reduce the cost of such services to their families and to the community.

TITLE III. WORKSHOPS AND REHABILITATION FACILITIES

The third major provision of this bill would provide the answer to a long-felt unmet need for additional rehabilitation facilities for the severely handicapped. Our own Opportunity Workshop rehabilitation program over the past 7 years has clearly demonstrated the need for more long-term or "terminal" workshops for the severely disabled. A substantial percentage of those individuals served in our workshop and similar programs have been able to achieve marked gains in functioning level and overall improvement in work adjustment without being able to attain the level of work competence required by private industry. If more long-term workshop facilities could be provided to these individuals it would enable them to sustain the gains achieved in these programs and at the same time provide them with dignified remunerative employment.

Our specialized experience with the psychiatric patient, in both our workshop and research project programs, appears to point up this need for a long-term facility for many psychiatric patients who ultimately might be rehabilitated. Since most of our present rehabilitation programs are geared to a relatively short time span of up to 1 year, many of the gains made by patients in this program are nullified or dissipated by the necessity of curtailing services to them beyond the officially approved period of time currently supported by the state rehabilitation agency. Cases II and III (see attached) are brief illustrations of psychiatric cases served in our Opportunity Workshop-Jewish Vocational Service program. They demonstrate that, where extension of service is given beyond the customary time, ultimate rehabilitation may be achieved. Thus, for example, in case II, successful rehabilitation was achieved in less than 1½ years' time. In case III, significant progress is still being made, with eventual hopes for rehabilitation still a possibility. It should be noted that, were the workshop facility not available in the community, neither case (based on past case histories) would have been able to remain out of the hospital for any significant period of time.

Case IV illustrates the need of marginally functioning ex-mental-hospital patients for sustained sheltered employment. This service is often the key factor in preventing hospital readmissions. The benefits derived by the individual and the community are manifold.

We would also recommend the establishment of sheltered workshops in institutionalized settings, such as hospitals, homes for the aged, convalescent homes, etc. It has been demonstrated, for example, that where a home for the aged in the Midwest developed a sheltered workshop program on a half-day basis, it was able to dispense with the services of two nurses, because of the diminished requests for medical and nursing care on the part of residents. Of course, the benefits gained in added physical well-being, as well as of dignity and feeling of usefulness on the part of residents, is self-evident. In the case of hospitals tied in with rehabilitation programs in the community, a sheltered workshop for chronic cases would eliminate the need for costly evaluation services which could be performed in the institutional setting.

In summary, therefore, we strongly urge the passage of H.R. 3465. Implementation of its various provisions would ultimately result in economies to the com-

munity and immeasurable dividends of improved health, both physical and mental, on the part of many individuals, increased earnings resulting in self-sufficiency for many others, added human dignity and increased well-being for many families and the community at large.

I sincerely hope that you and your committee will do everything possible to facilitate the passage of this vital piece of legislation.

Sincerely yours,

WALTER R. COHN, *President*.

CASE ILLUSTRATIONS IN CONNECTION WITH TESTIMONY RELATIVE TO BILL
H.R. 3465

CASE NO. 1

(Illustrates the need for evaluation services for the severely handicapped)

Mr. R is a deaf-mute with Parkinson's disease. He has a deaf-mute wife and two children. When first seen by the Jewish Vocational Service he was receiving public assistance in his local community. He came to us for job placement.

In his first interview his inability to communicate and a severe tremor in his left hand raised questions as to his employability. In order to assess his current level of employability, he was accepted for an 8-week diagnostic period in our opportunity workshop diagnostic rehabilitation program, under sponsorship by the New Jersey Rehabilitation Commission. During this 8-week evaluation he evidenced ability to perform gross motor tasks, such as packing and shipping. In fact, it was observed that when he was engaged in such tasks his tremor diminished. It was also observed that in a work situation he was able to communicate adequately, partially through lipreading and partially through primitive sign language.

Toward the end of his evaluation period the personnel director of a local concern was invited to visit the shop in order to observe him at work. The employer was quite impressed with his job performance and hired him. This same employer also informed the shop supervisor that, had he seen this client in a normal referral situation in his office, he would have turned down his application without any consideration whatsoever, because of the negative picture he presented in a formal interview.

CASE NO. 2

(Illustrates the need for extension of customary time limits of service for psychiatric patients)

Mr. M. is a 24-year-old single man who was referred to the Jewish Vocational Service while still a patient at Essex County Overbrook Hospital. His prior work history was spotty and characterized by unskilled jobs of short duration. His early childhood was spent in a series of institutions, foster homes, and homes of relatives. At first contact, his family preferred that he continue to remain in the hospital. However, the hospital felt that he was ready for discharge, and, in cooperation with the New Jersey Rehabilitation Commission, he was referred to JVS for evaluation of his work potential in the opportunity workshop program. Through a special cooperative arrangement with the hospital and the New Jersey Rehabilitation Commission, he was permitted to remain in the hospital during this evaluation period.

As might be expected from his previous history, his progress in the workshop was slow but steady. On the basis of the improvement shown during the initial evaluation period he was discharged from the hospital and, with the help of their social service department, arrangements were made for him to live in the community. Although greatly improved at the end of the year, the client was not quite ready for private employment, and the agency retained him beyond the customary 1-year period normally authorized by the New Jersey Rehabilitation Commission.

Following an additional 2 months' service he was successfully placed in private employment as a packer, where he is still employed. At this point we can report that he has been gainfully employed for over 6 months on the same job. It should be emphasized that, by continuing service beyond the customary period of time, a successful rehabilitation was effected.

CASE NO. 3

(Illustrates the need for long-term workshop services for severely handicapped mental patients)

Mr. J., a single man in his early forties, was seen while on leave from the New Jersey State Hospital at Greystone Park. He was accepted by the Jewish Vocational Service for our 8-week diagnostic evaluation in the opportunity workshop, under the sponsorship of the New Jersey Rehabilitation Commission. At the end of this evaluation period, due to the nature and severity of his illness, it was considered unlikely that this client could be returned to competitive employment within the 1-year period usually authorized by the New Jersey Rehabilitation Commission. In view of this, the commission terminated its sponsorship. Nevertheless, it was felt that eventual rehabilitation was still a possibility, without setting specific time limits. On this basis, he was continued in the workshop program.

After 1 year he is still not ready for employment but has derived the following benefits:

(1) This has been his longest sustained period outside a mental hospital in the past 10 years.

(2) He is a productive worker in the workshop.

(3) He has opportunity for social contacts otherwise unavailable to him.

(4) He has accepted regular psychiatric help.

At the present time his psychiatrist reports little likelihood of a relapse.

This case illustrates that, in working with the severely handicapped, many important gains can be accomplished and much improvement effected in many areas of functioning, even though the goal of immediate employment may require deferment.

CASE NO. 4

(Illustrates the need for terminal workshops)

Mr. L. entered the Essex County Overbrook Hospital at the age of 48, after several years of marginal employment and existence following the death of his parents. Always a seclusive, inadequate person, with many problems, Mr. L. had managed to maintain some employment, and thus avoided becoming a community financial or social problem as long as his parents were available to provide a home. Without them, he was unable to face these responsibilities.

After 14 months of hospitalization he was released into the community on the basis of acceptance by the Jewish Vocational Service for its opportunity workshop rehabilitation program. Exposure to a workshop program, plus attempts at trial placement, indicated that Mr. L. could not meet the demands of competitive private employment even on a minimal level and was unlikely ever to do so. However, he demonstrated the ability to function in and derive satisfaction from the workshop program. Termination of the opportunity workshop program for him would unquestionably have resulted in rehospitalization. On this basis, he was accepted as a terminal employee in the workshop. He still lives a marginal existence but the workshop has added a meaningful dimension to his life. It not only provides Mr. L. with a minimum level of financial support, but gives him an opportunity to be purposefully occupied during the day. Despite his many problems, he has sustained this program for the past 3½ years. Without it he would undoubtedly have been reinstitutionalized. Public assistance alone would not sustain him, since it makes no provision for meaningful activity for him.

There are many more individuals like Mr. L. who could remain out of mental hospitals if terminal workshop programs were more widely available. The savings in human resources and public funds are self-evident.

Mr. ELLIOTT. Our next witness is Mr. Percy Clark, of the New Jersey State Hospital, Marlboro, N.J.

Mr. Clark, I do not know if you were present earlier when I stated that each witness will be limited to 10 minutes in his testimony because of the large number of witnesses who have expressed desire to appear and testify here today.

If you have a prepared statement, I might suggest that you file the prepared statement with the reporter and summarize your views. Your prepared statement will follow your oral testimony in the record.

Mr. CLARK. Thank you.

Mr. ELLOTT. Or you may proceed in any other fashion if you desire.

STATEMENT OF PERCY L. CLARK, OTR, REPRESENTING NEW JERSEY OCCUPATIONAL THERAPY ASSOCIATION

Mr. CLARK. I do have a prepared copy that I will leave with the secretary.

I am representing the New Jersey Occupational Therapy Association.

The following are the urgent needs that we have experienced and recognized as occupational therapists preparing patients to be more independent, responsible members of society.

More sheltered workshops are needed and we feel also that a job placement service should be an integral part of this program to help shorten the time spent in the workshop.

One of the most urgent needs is the sheltered workshops accepting psychiatric patients who still require some supporting during the initial adjustment period in the community and at the same time give him an opportunity to contribute to his own support.

We also must meet the needs of those who cannot fit into competitive industry, such as those with progressive conditions who are not eligible under the present legislation.

And those with multiple handicaps who can attain such measures of self-support.

Secondly, we need more adequate professional services for the homebounds who with maintenance therapy administered in the home could be productive in homebound employment of a limited nature.

Thirdly, we also need have halfway houses for the individual without a home or family who could be discharged from the hospital either with a residual physical handicap or on a convalescent status from a mental hospital into a protective independent living situation, such as the loneliness of the feeling of rejection by society, especially with the psychiatric patient.

Also, some disabilities who may require some self-care. This type of setup would not require a highly trained person and this would not necessitate taking the professionally trained personnel from vital rehabilitation centers.

Again we feel that more generous provision for prosthetic devices and orthopedic equipment services are needed for convalescent patients who are not presently eligible.

Also, especially in the psychiatric area. We also feel that more counseling services must include the families of the handicapped in cases where the disability of the breadwinner necessitates a former dependent assuming the role.

Also, counseling the family to accept the shift in the roles. And vocational counseling or training for the new breadwinner.

We also feel that one of the greatest needs is more professionally trained personnel. In occupational therapy alone there are job opportunities for 14,000 registered occupational therapists in addition to the present 6,106 registered therapists.

Also, enrollment in the occupational therapy schools has decreased due to high tuitions which may mean that some of the schools may not be able to continue the curriculums.

Financial assistance is needed for extending recruitment and publicity programs.

Financial assistance such as tuition and living should be made available to potential students as part of the recruitment program.

Scholarships for graduate work for registered occupational therapists would improve the quality of professional services.

And higher salaries are required to attract and keep greater numbers of personnel.

Mr. ELLIOTT. At that point what do you feel is the role of the Federal Government in this area?

Mr. CLARK. We feel that under grants especially the recruitments could be assisted in getting more people interested and more people in the field.

Mr. ELLIOTT. Grants to colleges and universities to encourage study along that line?

Mr. CLARK. That is right.

Mr. ELLIOTT. Are there any questions?

Dr. BARNARD. Mr. Chairman, I have a letter from Mr. Harold G. Logan, director, New Jersey Consultation Service for Convulsive Disorders. He would like to express his appreciation for being invited to testify before this subcommittee on this important legislation and present a statement regarding the program here in the State of New Jersey and the efforts of his clinic to work with convulsive disorder patients.

I respectfully request that Mr. Logan's letter and statement, be made an official part of the record.

Mr. ELLIOTT. Without objection, the statement of Mr. Logan and the formal statement of Mr. Clark, will be made a part of the record at this point.

(The statements referred to follow:)

STATE OF NEW JERSEY,
NEW JERSEY NEUROPSYCHIATRIC INSTITUTE,
Princeton, N.J., February 17, 1960.

HON. CARL ELLIOTT,

Chairman, Subcommittee on Special Education, Committee on Education and Labor, House of Representatives, Congress of the United States, Washington, D.C.

DEAR CONGRESSMAN ELLIOTT: As director of the New Jersey Consultation Service for Convulsive Disorders and secretary to the Advisory Council of the New Jersey Consultation Service for Convulsive Disorders, I have been asked to express our appreciation at being invited to testify before the Subcommittee on Special Education at the eastern Atlantic region hearings in Jersey City, N.J. on February 18, 1960. We are submitting to the Subcommittee on Special Education the enclosed statement and material regarding this program which represents the State of New Jersey's efforts to work with our convulsive disorder patients.

This program represents some of the efforts of our State government, medical profession, and lay groups to better the conditions of the convulsive disorder patients. This is accomplished by making available to their physicians the latest medical advances in the field of epilepsy and by utilizing the services of a non-medical group to help these patients with problems of education, employment, rehabilitation and adjustment to living in the homes and communities.

The enclosed material will more adequately describe the activities of the New Jersey Consultation Service for Convulsive Disorders and its advisory council.

Sincerely yours,

HAROLD G. LOGAN,
Director, New Jersey Consultation Service for Convulsive Disorders.

THE NEW JERSEY CONSULTATION SERVICE FOR CONVULSIVE DISORDERS

In 1950 it was estimated that there were approximately 20,000 persons with epilepsy in New Jersey. Studies made in other States indicated that many epileptics were denied education, employment, and the right to lead normal productive lives as members of their communities because of the lack of public understanding and the social problems accompanying epilepsy. It was also accepted that in most places there were not available the resources for the treatment of the medical problems. In our own State of New Jersey, we had one institution for epileptics, the State village at Skillman, whose function at that time was almost entirely custodial. It was generally felt that the situation in New Jersey approximated that in other States where more detailed studies had been made.

New Jersey currently has a traveling consultation service which meets five times each month in hospitals serving all of the health districts in the State. Dr. James F. Hammill, a noted neurologist, who in his capacity as chief epileptologist for the State department of institutions and agencies, sees patients who have been referred to the New Jersey Consultation Service for Convulsive Disorders by their private physicians. These patients, prior to being seen by Dr. Hammill, have had complete neurological examinations from a local "contact physician" who had been specially trained to work with the epileptic patients. The patients are also given electroencephalographic tests, and if necessary, X-rays, blood tests, etc. A trained psychiatric social worker has thoroughly interpreted the program to the patients and their families and secured pertinent material regarding their home, job and educational situation. At the actual clinic session, which is attended by professional observers, the patient's total problems are reported by the contact physician and social worker. Dr. Hammill examines the patient and discusses with him, the findings and answers the patient's questions regarding their condition. The patient is informed of the recommendations for treatment of his case and advised to return to his private physician to whom is sent the findings and recommendations. If the patient needs assistance in the area of rehabilitation, social casework, education, etc., this is also indicated to the referring physician and assistance is given in helping make the proper arrangements for his patient.

Credit for this program for convulsive disorders in New Jersey goes to the New Jersey Medical Society. Aware of the situation here in New Jersey, the idea for the program was created by the members of the subcommittee on public health of the State medical society in 1950. We here in New Jersey were fortunate in that one of our physicians had lived in Ohio where a program for epileptics had been in operation for a number of years. The Ohio program had been underwritten by the Ohio Chapter of the National Society for Crippled Children and Adults. After some months of discussion and study, the New Jersey plan was approved by the Subcommittee on Public Health, the Welfare Committee and the board of trustees, all of the New Jersey Medical Society. The proposed State plan regarding epilepsy was submitted to the New Jersey Chapter of the National Society for Crippled Children and Adults with a request for the financial and personnel aid required to put the program into effect after receiving full approval of the New Jersey Medical Society.

Through the inspired guidance of Mr. Donald M. Smith, executive director of the New Jersey Society for Crippled Children and Adults, the proposed plan was given housing, publicity, direction, and agency sponsorship. Through funds made available to the New Jersey Society for Crippled Children and Adults by a group which had been formed in 1950, the New Jersey Society for the Welfare of Epileptics, the services of Mrs. Emma Galloway Cole, a medical social worker, were obtained as epilepsy project coordinator. Mrs. Cole was able to put into operation the program recommended by the New Jersey Medical Society.

In the beginning the program was mainly educational in nature and consisted of institutes held throughout the State and the dissemination of material regarding the epileptic and his problems. Funds for carrying out the remainder of the proposed program, hiring the personnel for the traveling clinics, were not available either through public or private sources.

In 1952, Mrs. Cole received an award from the National Institute of Neurological Diseases and Blindness which made it possible for her to visit other States across the country to observe firsthand their way of handling the problem of the epileptic. During this tour she was able to study in detail the pro-

gram of the State of Ohio. Upon her return to New Jersey, a revised plan was recommended, patterned after the Ohio program but geared specifically to meet the needs of New Jersey. During this period, discussions were held with many of the leading authorities in the field of epilepsy who offered their comments and experience in the development of the traveling clinic plan being considered for New Jersey. This phase of the program was highlighted in 1953 by the State department of institutions and agencies which agreed to underwrite the salaries of the personnel which would make the consultation service as it exists today a reality.

In this same time period another very important development was occurring in New Jersey which aided the development of the consultation service and saw it emerge as a jointly sponsored activity of the department of health and department of institutions and agencies. The State Village for Epileptics at Skillman was reorganized and became known as the New Jersey Neuropsychiatric Institute and had as its function to promote research and study of neurological and psychiatric disorders. The population of the epileptic village was reclassified and patients were sent to the proper institution as needed or plans were made to return them to their homes and communities. At the same time the division of chronic illness control was organized as a unit of the State health department. Under its charter, the newly created division of chronic illness control felt that epilepsy was one of the diseases with which they should work. At this point, discussions were carried on by the department of institutions and agencies, department of health and the New Jersey Society for Crippled Children and Adults to coordinate their activities in this field. The medical society had recommended the setting up of an advisory council (see exhibit 4 and 5) which would serve as policymaking body for the consultation service. Through the cooperative efforts of the three agencies, the New Jersey Consultation Service for Convulsive Disorders was set up in 1953.

The department of institutions underwrote salaries of the medical consultant, the contact physicians, the psychiatric social worker, and clerk stenographer. The health department purchased and loaned to the hospitals selected as clinic sites, EEG machines and provided grants for the training of EEG technicians. The health department also provided printed materials, the planning for the April 1954, Governors Conference on Epilepsy and other vitally related services. The New Jersey Society for Crippled Children and Adults provided the salary of an educational-vocational counselor and office space for the program. After another period of discussion and training sessions, the New Jersey Consultation Service for Convulsive Disorders held the first practice clinic on November 5, 1953. Because of certain internal problems, no further clinics were held until March 1954, at which time the clinic program was begun with four clinics operating each month in each of the four State health areas. The need for an additional clinic for the metropolitan health area was soon made necessary but it was not until January 1959, that the fifth clinic was set up. The four clinics and a description of the present program is described in exhibit No. 3.

Since the inception of the clinic program, the consultation service has made a most important contribution to the handling of the problems of the epileptics. The following chart will illustrate the statistical breakdown of the program.

Statistical table, May 1954 to June 1959

Number of doctors referring-----	1, 022
Number of patients referred-----	1, 269
Number of clinics held-----	221
Total patients examined (original and reexaminations)-----	1, 510
Number of visitors to clinic-----	4, 002
<hr/>	
Family members-----	1, 597
Professional observers-----	2, 405

With the reorganization of the State village at Skillman, the consultation service was given two important tasks directly concerned with the New Jersey Neuro-Psychiatric Institute: all epileptics now seeking admission to the New Jersey Neuro-Psychiatric Institute are screened by the consultation service. Prior to taking on this responsibility, the annual admission rate to the Skillman village ran around 250 admissions per year with over 800 patients being maintained at the village as chronic institutional cases. Since the consultation

service has been in operation, the greatest number of admissions to the institute in any one year has been 12 admissions. These patients were admitted for intensive evaluation and treatment with the average time of residence being 3 months. After this period of inpatient treatment, these patients were returned to their homes and communities to continue living normal productive lives. These patients have ranged in age from 10 to 60 years of age. The other responsibility given the consultation service was to give followup services to those epileptic patients who had been returned to their homes and communities at the time of the village reorganization, thus insuring them one of the services, making it possible for them to continue as productive members of society.

Early in the clinic program, it was recognized that in order for the consultation service to render the most effective service to the epileptics, that a close tie-in with existing community services would have to be made. This has been noticeably demonstrated throughout the operation of the program. An agreement providing for mutual referrals to the local offices of the New Jersey Rehabilitation Commission, State employment service, State mental hygiene and local mental hygiene clinics was initiated. This made it possible for the patient to receive the benefit of total available services as envisioned in the early planning for the program. In the area of special education, the consultation service has had a very practical and workable relationship with the director of special education in the State department of education. Through this relationship, the problems of the epileptic schoolchild have received firsthand attention and we now can proudly state that the epileptic schoolchild in New Jersey, with the resources of all of our State and private organizations, are now able to take their places in our educational system. Another very important adjunctive service rendered the patients was made possible by an agreement with the State department of health through its nursing program. Patients now receive nursing followup care in these cases where indicated with the approval of their family physician.

This program has been widely accepted by the physician in New Jersey treating the epileptic patient. A review of the preceding statistical table will show this as reflected in the numbers of referrals made by the physicians, and more importantly, by the fact that their patients have benefited through the services made available to them and their ability to resume their places in the lives of their families and activities of their communities.

The early plan for the epilepsy program called for the organization of an advisory council to the consultation service. This council with representation from both public and lay groups, would serve as general policy making body for the epilepsy project. (See exhibits Nos. 4 and 5.) Through the efforts of this group, New Jersey in 1959 revised its statutes now making it legal for epileptics to marry. The advisory council has worked in other areas to help effect better legislation regarding the epileptics in the area of labor, rehabilitation, and education. The advisory council has also worked with the State division of motor vehicles to effect a better policy of issuing drivers licenses to the controlled epileptic.

The advisory council has played a most important part in the activities of this program. The wealth of experience that the members of the council have brought to play on the problems of the epileptic have clearly demonstrated the vulnerability of all diseases and illnesses when all of the resources in an area are combined to solve the problems presented by illnesses and disability. We feel that we have made a good start here in New Jersey and are looking to the future when we can feel that the epileptic patient no longer will have to contend with the stigma so long attached to epilepsy.

EXHIBIT No. 1

THE MEDICAL SOCIETY OF NEW JERSEY—RECOMMENDED STATE PLAN REGARDING EPILEPSY

NEED OF AN EPILEPSY EDUCATIONAL AND SERVICE PROGRAM IN NEW JERSEY

It has been estimated nationally that there is 1 person afflicted with epilepsy in every 200 of the general population. If this is true, then there would be something over 20,000 epileptics in the State of New Jersey.

Studies elsewhere have shown that many epileptic persons are kept out of school or have been unable to get employment because of the lack of public

understanding of the disease and an organized approach to the social problems incident to it. There is also in most places a lack of organized methods to assure proper treatment of the epileptic as an individual.

The only institution for epileptics in New Jersey is the State village at Skillman and its function, at present, is almost entirely custodial.

Authorities say that 75 to 80 percent of all epileptics can lead a normal or near-normal life if treatment is available and applied to their cases and if the public understands their problem. Epileptic seizures can be completely controlled in more than half of all epileptic patients by adequate treatment with accepted medication.

Recent advances in diagnosis and treatment have altered the concepts that (1) epilepsy is usually associated with mental retardation, (2) no satisfactory treatment is available, and (3) epileptics are chronic invalids.

The primary objective of an epilepsy program should be to make the public aware that the epileptic person should be treated as an individual and should not be rejected because of his disorder.

SUPERVISION AND DIRECTION OF THE PROGRAM

Upon approval of the program outlined below by the State medical society, these proposals will be submitted to the New Jersey Chapter of the National Society for Crippled Children and Adults with a request for the financial and personnel aid required to put the program into effect.

In order to coordinate the interest and resources of all the agencies, public and private, which should be concerned with a statewide epileptic program, it is proposed first to establish an advisory council on the epileptic program to comprise representatives of the Medical Society of New Jersey, the New Jersey Chapter of the National Society for Crippled Children and Adults, the State department of health, and the State department of institutions and agencies, the State department of education, the State department of labor and industry, and the State rehabilitation commission.

Apart from and in addition to this council, there would be a medical advisory committee, the members of which would be designated by the Medical Society of New Jersey. All medical policies and any changes in medical policy shall be adopted by the council only after approval by the medical advisory committee.

The council would select a coordinator for the entire program, whose salary and approved expenses would be paid by the New Jersey Chapter of the National Society for Crippled Children and Adults, if the program is accepted by that organization. (It may be found preferable, in this connection, to designate the executive director of the New Jersey Chapter of the National Society for Crippled Children and Adults as the coordinator for the program with the actual work to be delegated by him to a subordinate, specialized member of his staff.)

OUTLINE OF PROGRAM

1. The coordinator, with the aid and guidance of the council and medical advisory committee, will seek to enlist the cooperation of the medical profession, school authorities, health officers, and employment personnel in developing plans to aid the epileptic and to inform and educate the public and professional groups in the part they can play in helping epileptics to lead normal lives in school, at work or in the community.

2. The coordinator will maintain lists of treatment facilities and of physicians interested in treating epileptic patients. He will compile lists of private schools, camps, and other facilities where epileptics will be accepted. He will maintain an information exchange on employment, education, and legal questions concerning the epileptic.

3. The coordinator will be available for consultation with epileptic patients, their friends and relatives, for advice on meeting individual or personal problems.

4. The coordinator will cooperate with the authorities in the department of institutions and agencies and with the medical advisory committee in helping to publicize and promote the use of such central treatment, clinical, and educational services as may be available under the department at Skillman Village.

5. Eventually, it is anticipated that the medical advisory committee will give consideration to the desirability of organizing demonstration clinics operating out of the treatment center at Skillman Village for instruction and consultation

purposes to assist physicians, nurses, teachers, etc., in handling problems of their epileptic patients.

It is understood that treatment would not be given at these traveling clinics. Patients would be accepted by the clinic only on reference by private physicians and recommendations would be sent directly to those physicians. Detailed arrangements as to engagement of a consultant, fees to be paid, and the relationship with private neurologists would be worked out in advance by the medical advisory committee.

It would be anticipated that a traveling clinic would enter a county only with prior knowledge and approval of the county medical society. A primary purpose of such traveling clinics would be to provide special services to physicians treating epileptic patients.

6. Special studies would be undertaken by the coordinator, the council and the medical advisory committee in relation to the educational needs of the epileptic child, the need for vocational rehabilitation and placement of the epileptic adult, and possible improvements in legal statutes governing epilepsy.

RECOMMENDATIONS

The advisory committee on mental hygiene has approved the epileptic plan as above presented and recommends that the public health committee approve it and recommend its approval by the welfare committee.

NOTE.—This outline follows closely the program that has been developed and has been in operation for approximately 3 years in Ohio. Through correspondence with the executive secretary of the Ohio State Medical Association, we are assured that this program not only has been successful but highly satisfactory to the physicians in that State. In Ohio, the financial and personnel requirements of the program have been underwritten by the Ohio Chapter of the National Society for Crippled Children and Adults and the direction of the plan is in the hands of councils and committees comparable to those above proposed for operation of the plan in New Jersey.

EXHIBIT No. 2

THE NEW JERSEY SOCIETY FOR CRIPPLED CHILDREN AND ADULTS PLAN FOR NEW JERSEY CONSULTATION SERVICE FOR CONVULSIVE DISORDERS

THE CLINIC PLAN

The plan outlined below for community convulsive disorder clinics in New Jersey is the result of a study of such clinics in operation in 11 States across the continent. This plan has been approved by Dr. Robert Garber, superintendent of the New Jersey Neuro-Psychiatric Institute at Skillman, by the medical advisory committee of the epilepsy project representing the medical society of New Jersey and by the advisory council to the epilepsy project of the New Jersey Society for Crippled Children and Adults. It is based primarily on the Ohio plan for traveling consultation clinics, but modifies that plan by proposing permanent community clinics with a traveling rehabilitation team. The primary purpose of the community clinic and the rehabilitation team servicing it is—

1. To give expert consultation to physicians in the community in the treatment of patients with epilepsy, who may be unable, because of the patient's economic status, to refer patients to a private source.
2. To demonstrate to other interested physicians, the most advanced methods of diagnosis and medical procedure for persons with epilepsy and to give interested nurses, teachers, vocational counselors, social workers, and other professional personnel interested in epilepsy the most advanced methods of care relative to their respective fields of endeavor.
3. To bring to the patient with epilepsy the ancillary benefits of a team whose function is to discover, initiate, and promote community services leading to total rehabilitation.

THE CONSULTANT

Representing Dr. H. Houston Merritt, director of the service of neurology at Neurological Institute, Presbyterian Hospital, and professor of neurology at Columbia University, New York City, will be his staff member, Melvin D.

Yahr, M.D. Dr. Yahr will serve as consultant to the consultation-demonstration clinics, as leader of the rehabilitation team which will service the clinics, as director of the medical research anticipated as a function of the clinic and will add a continuous teaching element to the plan. This element will be effective especially in relation to the contact physicians working with Dr. Yahr but will also reach out to referring physicians and others who use the consultation and demonstration functions of the clinics. His activities as consultant will not involve direct treatment.

INCORPORATION OF CERTAIN PHYSICIANS AS KEY PERSONNEL

A local physician, preferably experienced in epilepsy, ready to learn and sincerely interested in the epileptic individual as a whole person will be chosen from each of four sections of the State known as health districts. In each district an accessible town with an available hospital or center, will be chosen, in consultation with the local physician, as a base or center.

SUGGESTED ORGANIZATION

This physician will be requested to act as key medical person for the traveling rehabilitation team in his area, e.g., Morristown for north Jersey, etc. He would be asked to be contact person in all of the relationships of the traveling rehabilitation team in this area, and if possible organize a seizure clinic in the hospital which he attends for indigents and medically indigent (such a clinic is not already operating).

COOPERATION OF LOCAL ORGANIZATIONS

Because there would be geographically relatively easy access to the chosen centers from all parts of each area, it is believed that the transportation problem will not be great. However, where such a local problem does appear the co-operation of the local county committee on epilepsy, which presumably has been previously formed, or the local chapter of the Society for the Welfare of Epileptics, where available, will be sought. Thus the responsibility in such local situations will continually be thrown back to the home base.

Experience in other States has proven the very great importance of keeping such responsibility at the grassroots. It will be the function of the contact physician to keep the local referring physician informed as to the best methods of treatment and to act as a readily available source of consultation, so that the local physician may be continually aided in the most recent and skilled methods of seizure control.

SELECTION AND PREPARATION OF CONTACT PHYSICIAN

The contact physician representing each of the four service districts will be chosen on the recommendation of his county component medical society on the basis of the following qualifications:

1. An interest in convulsive seizure problems and a leaning toward neurology as an ultimate specialty. Interest in using new methods and medications for control of seizures under the guidance of the clinic consultant.
2. Availability of sufficient time to devote 1 full-day and several shorter periods each month to clinic activities.
3. Capacity to cooperate in a teamwork activity.
4. Age preferably not over 40.

Some special orientation will be needed in order that each contact physician will be fully prepared to work in harmony with the consultant. A series of half-day sessions for special lectures and clinic participation at neurological institute is given to the physicians chosen. Thereafter, these physicians will use the consultant with judgment, as needed. The training of these physicians will be such that they can provide some followup consultation to physicians who have referred patients to the consultation-demonstration clinic, and use consultation with New York with discretion in emergencies. It will be essential for them to be able to work efficiently with the newer drugs, also using the consultant as needed.

Benefits to the contact physicians will include therefore:

1. Special training course of 6 to 8 half-day lectures and practicum sessions at Neurological Institute, New York. Other special training opportunities.

2. Continual consultation and orientation in most recent methods of diagnosis and treatment of convulsive seizures.
3. Encouragement to develop a convulsive disorder clinic at an appropriate hospital in the area.
4. Probable retainer of approximately \$2,000 a year.

OPERATION OF TRAVELING REHABILITATION TEAM

A traveling rehabilitation team headed by the consultant epileptologist and coordinated by the coordinator of the epilepsy project, to serve the community clinics, is to be set up. A visit will be made each month to each district by the group, consisting of the consultant, coordinator, social worker and vocational counselor. To this team in each district will be added the contact physician of that area. Experience and practice in other States indicate that the electroencephalographer might profitably be included on this team and that an E.E.G. study should be done, if indicated. A psychologist and a nurse representing the locality from which the patient comes would also be valuable team participants. It is believed that the number studied in each clinic session may be rapidly increased without loss of efficiency through the continual close relationship which the contact physician will have with the team and the referring physician.

THE ELECTROENCEPHALOGRAPH MACHINE

Through the cooperation of the division of chronic disease control of the State department of health a plan is being worked out for greatly enlarged electroencephalographical services in each of the four districts. The division will install E.E.G. machines in hospitals where the need justifies such a loan of equipment. This will primarily be for the use of the consultation-demonstration clinic in this area but will also serve others. Grants-in-aid for technicians' services will also be supplied under this cooperative plan.

SUMMARY

The value of the new features of this plan lie in several areas:

VALUE OF NEW PLAN

1. The teaching element of the plan: The training and utilization of contact physicians which (a) brings consultation close to the referring physician, (b) keeps responsibility in the community (c) may prepare the contact physician to become consultant in his area at a later date.
2. The enlarged capacity of the clinic: The contact physician increases the amount of help available to the referring physician many times, and assures prompt and readily available access to this consultation.
3. Assurance to local neurologists that the visiting neurologist as consultant, does not seek to replace them but does make readily accessible consultation in continual touch with developments in the most modern methods, for the use of the family physician as well as for the specialist.
4. Continual development of work in epileptology: With the contact physician working closely with the consultant, the sharpening of special skills and the experience in teamwork approach to rehabilitation processes should make it possible for these men to replace the New York consultant in a few years time as was done in Ohio after the death of Dr. Jerry Price. Each one would then become a teacher of other future epileptologists. It is recommended that when that time comes, some regular refresher process be required of the physicians who take over as consultants to assure that, until New Jersey has its own school of medicine, the very latest treatment be continually available.

COST

The cost of this plan is being shared by the department of institutions and agencies (who will provide most of the staff salaries, through the New Jersey Neuro-Psychiatric Institute) the division of chronic disease control of the department of health (by supplying E.E.G. machines and facilities for them and a large share of the physical equipment, printed matter, etc.) and the New Jersey Society for Crippled Children and Adults which will coordinate the three agencies and supply part of the staff and office equipment.

Exact figures are not available at this time, but it is believed that by the co-operative plan now being set up a maximum of benefit with a minimum of loss through duplication and overlapping may be developed, all to the ultimate benefit of the person suffering from epilepsy and its attendant effects.

EXHIBIT No. 3

NEW JERSEY CONSULTATION SERVICE FOR CONVULSIVE DISORDERS

Medical Consultant, James F. Hammill, M.D.; director, Harold G. Logan, M.S.W.

This service is for consultation and demonstration only. Physicians may refer patients economically unable to be referred to a private consultant, by filling out and sending referral forms to the director. Referral forms may be secured from the local county medical society, from the District Health Office, or from the above address. If the attached information does not answer all questions, the director or the contact physician in your area may be addressed or phoned.

CENTERS AND CONTACT PHYSICIANS

Southern area. (Atlantic, Camden, Cape May, Cumberland, Gloucester, and Salem Counties) :

Salem County Memorial Hospital, Salem.

William L. Sprout, M.D., Salem.

Metropolitan area. (Bergen, Essex, Hudson, and Passaic Counties) :

Paterson General Hospital, Paterson.

Melvin B. Robbins, M.D., Fair Lawn.

The Presbyterian Hospital, Newark.

Francis Wood, M.D., Newark.

Central area. (Burlington, Mercer, Middlesex, Monmouth, and Ocean Counties) :

St. Francis Hospital, Trenton.

Arthur Randelman, M.D., Trenton.

Northern area. (Hunterdon, Morris, Somerset, Sussex, Union, and Warren Counties) :

Morristown Memorial Hospital, Morristown.

Catherine Spears, M.D., Chatham.

SCHEDULE

On occasion, the clinics are moved from place to place. Persons desiring to attend clinic sessions should call the above telephone number to determine actual date and place of clinic.

First Monday of month : Southern area.

Second Monday of month : Metropolitan area.

Third Monday of month : Central area.

Fourth Monday of month : Northern area.

NEW JERSEY CONSULTATION SERVICE FOR CONVULSIVE DISORDERS

What the consultation service is

The consultation service is designed to make available the advantages of newest medical and rehabilitation techniques to physicians and their patients throughout the State by means of a clinic held each week in one of the four areas of the State as scheduled on page 1. Each consultation service clinic is a demonstration in these techniques and is open for observation by physicians and other professional persons working with people with seizures.

The consultation service program is based on the conviction that with the advantages of modern drugs and medical techniques, most people with epilepsy and other convulsive disorders no longer require institutional care. The consultation service clinics are designed to make available to patients, in their own communities, the most modern care and to help them to find acceptance and productive roles as part of those communities.

The consultation service acts as a screening unit to the New Jersey Neuro-Psychiatric Institute in those instances where requests are made for admission on the basis of epilepsy.

The rehabilitation team

At the consultation service clinics, patients referred by the private or hospital clinic physician are examined by James F. Hammill, M.D., who is also a consultant epileptologist to the New Jersey Neuro-Psychiatric Institute. Each patients social, educational and vocational problems are also studied by a social worker and others who work as a team with Dr. Hammill.

Recommendations for medication or other medical care—as well as for help in nonmedical areas—are sent by Dr. Hammill to the referring physician, who continues to treat his patient. The nonmedical rehabilitation team members are available to help find solutions to patients' difficulties in family, community, school and employment relationships.

The "contact physicians"

Assisting Dr. Hammill as "contact physicians" in the four areas of the State are the five physicians listed on page 1. The contact physicians, all of whom have had special orientation courses by Dr. Hammill, prepare patients for the service clinics and provide a local avenue of followup information for referring physicians after patients have been seen at the consultation service clinics.

The coordinated program

1. State department of institutions and agencies through its New Jersey Neuro-Psychiatric Institute.

When the former Skillman Village for Epileptics was reorganized in 1952 into the New Jersey Neuro-Psychiatric Institute, it undertook an active program of preparing and discharging to their homes, those patients capable of functioning in the community. It undertook also the task of fostering development of community resources to provide necessary care for these patients, and for the much greater number of seizure patients in New Jersey communities who have never been institutionalized and who with adequate community care, will not need institutionalization. The institute participates in the consultation service, providing the services of Dr. Hammill and the contact physicians, the social worker, stenographic help, the director and other services.

New Jersey Neuro-Psychiatric Institute, Box 1000, Princeton, N.J. Robert E. Bennett, M.D., medical director.

2. State department of health, through its division of chronic illness control.

The division of chronic illness control, as part of its program of discovery, prevention and research in long-term ailments, provides each of the five hospitals listed on page 1 with an electroencephalographic machine and a trained EEG technician to assure consultation service patients access to this important diagnostic facility. The EEG machines, each located in an area having little or no similar facilities, also are available for use of other patients according to the policies of each hospital. The division also provides the consultation service with printed material and other services.

Division of Chronic Illness Control, 211 East State Street, Trenton, N.J. Marian R. Stanford, M.D., director.

Other agencies and organizations contribute to the effectiveness of the service in many cooperative ways.

Availability of the service

The New Jersey patients in need of specialist consultation for seizure problems but financially unable to be referred to a private consultant are eligible for consultation service when referred by their clinic or private physician by use of a referral form. No treatment is given by the consultation service, whose function is only for consultation and demonstration. Preparing of case history and scheduling for the clinic may require some time following receipt of the referral form at service headquarters.

Cost

There is no cost to referring physician or to patient for the consultation service. When special diagnostic services, other than EEG are required, they are sought in the community from which the patient comes. For cases having need for services unobtainable in their own communities, the Society for the Welfare of Epileptics has made funds available to the consultation service, for use under special circumstances.

Procedure for New Jersey consultation service for convulsive disorders

1. Referral form sent by private or clinic physician to headquarters of consultation service, New Jersey Neuro-Psychiatric Institute, Box 1000, Princeton, N.J.
2. Case prepared for clinic appearance. Patient seen by contact physician and social worker to perfect referral information.
3. Notice of time and place of clinic appointment sent to patient, referring physician and to others indicated.
4. Patient seen by Dr. Hammill and team members at clinic.
5. Report and recommendations sent to referring physician.
6. In liaison with referring physician, team members undertake indicated referral to nonmedical services, and followup is arranged.
7. Contact physician available for followup consultation with referring physician.
8. Patient scheduled for reappearance at clinic as indicated.

EXHIBIT No. 4

BYLAWS OF ADVISORY COUNCIL TO THE NEW JERSEY CONSULTATION SERVICE FOR CONVULSIVE DISORDERS

ARTICLE I. NAME

The name of this organization shall be the Advisory Council to the New Jersey Consultation Service for Convulsive Disorders.

ARTICLE II. LOCATION

Officers of this council shall be the headquarters of the New Jersey Consultation Service for Convulsive Disorders.

ARTICLE III. PURPOSES

Purposes of this council shall be :

A. To bring together representatives of agencies and organizations, government and voluntary, concerned with New Jersey residents who suffer convulsive seizures (epilepsy) to the end that the interests and resources of these organizations and agencies may be coordinated and made more effective in serving those suffering convulsive seizures (epilepsy).

B. To serve as the general policymaking body for implementation of the epilepsy project outlined in the State plan regarding epilepsy which was formulated by the Medical Society of New Jersey and approved by its board of trustees, April 16, 1950, and which is an addenda to these bylaws.

ARTICLE IV. MEMBERSHIP

Section 1.—Membership in this council shall consist of one formally designated representative, who may have an alternate, from each of the following agencies and organizations :

- Medical Society of New Jersey.
- State Department of Health.
- State Department of Education.
- State Department of Institutions and Agencies.
- State Department of Labor and Industry.
- New Jersey Society for the Welfare of Epileptics.
- New Jersey Neuro-Psychiatric Association.
- New Jersey Mental Health Association.
- New Jersey Industrial Medical Association.
- New Jersey Chamber of Commerce.
- New Jersey A. F. of L.
- New Jersey CIO.

and representatives of such agencies and/or organizations and individuals as the council may from time to time invite to membership.

Section 2.—Membership in the council shall continue so long as the member is the formally designated representative or alternate of one of the organizations or agencies named in section 1 of this article, or of an agency or organiza-

tion which has been invited by vote of the council to designate a member. If a member fails to attend or be represented by an alternate at three consecutive council meetings, the council may request designation of another member from the organization or agency he represents.

ARTICLE V. OFFICERS

Section 1. Number and term of office.—The officers of this council shall be a chairman and vice chairman who shall be elected from the membership to serve until the next annual meeting of the council, or until their successors have been elected. No officer shall succeed himself in office for more than two successive terms. The director of the New Jersey Consultation Service for Convulsive Disorders shall serve as secretary to the council.

Section 2. Nomination and election.—The chairman shall appoint, not later than 30 days before each annual meeting, a nominating committee of three members one of whom shall be designated as chairman. Such nominating committee shall submit at the annual meeting the names of nominees for election as chairman and vice chairman of the council. Nominations also may be made from the floor at the annual meeting. An election shall be held at each annual meeting, nominees receiving the highest number of votes shall be duly elected, taking office immediately.

Section 3. Vacancies.—Vacancies among the officers arising from any cause whatsoever shall be filled by vote of the council at its next meeting. Officers so elected to vacancies shall serve until the next annual meeting.

ARTICLE VI. DUTIES OF OFFICERS

Section 1. Chairman.—The chairman of the council shall preside at all meetings of the council, appoint and be ex officio member of all committees authorized by the council, and perform such other duties as usually pertain to such office.

Section 2. Vice chairman.—In the absence of the chairman the vice chairman shall preside at meetings of the council, and perform such other duties as the council may designate.

ARTICLE VII. DIRECTOR

The director of the New Jersey Consultation Service for Convulsive Disorders as provided in the State plan regarding epilepsy, shall under direction of the medical director of New Jersey Neuro-Psychiatric Institute, and this council, serve as secretary and administrative officer for the council.

The director of the New Jersey Consultation Service for Convulsive Disorders as provided in the State plan regarding epilepsy, shall be a member of the staff of New Jersey Neuro-Psychiatric Institute. The director, under supervision of the medical director of New Jersey Neuro-Psychiatric Institute shall administer the affairs of the project. The director shall attend all meetings of the council and council committees, serving as secretary and participating in the deliberations. The director may seek guidance and help pertinent to the work of the project from any member of the council at any time.

ARTICLE VIII. MEETINGS

The council shall meet at least three times annually at times which shall be established by the council at the annual meeting which shall be held in October. Special meetings shall be held upon the call of the chairman or by petition of a majority of the council members. At least 10 days' notice in writing shall be sent by the secretary to all council members for all meetings. Persons or groups of persons other than those authorized to attend by these bylaws, may attend council meetings at the invitation of the council.

ARTICLE IX. QUORUM

At any meeting of the council a majority of the members shall constitute a quorum.

ARTICLE X. AMENDMENTS

These bylaws may be amended or revised by the council at any regular or special meeting of the council, provided that the proposed amendment shall have been presented at a preceding meeting or notice of the proposed amendment shall have been sent to all members with notice of the meeting.

NOTE.—The bylaws were revised by the advisory council on January 16, 1958.

EXHIBIT No. 5

ADVISORY COUNCIL OF THE NEW JERSEY CONSULTATION SERVICE FOR CONVULSIVE DISORDERS

Officers:

Mr. John W. Hayden, Esq., chairman, 407 Walker Road, West Orange, N.J.
 Robert E. Bennett, M.D., vice chairman, medical director, New Jersey Neuro-Psychiatric Institute, Box 1000, Princeton, N.J.

Mr. Harold G. Logan, secretary, director, New Jersey Consultation Service for Convulsive Disorders, New Jersey Neuro-Psychiatric Institute, Box 1000, Princeton, N.J.

Members:

Department of institutions and agencies:

John W. Tramburg, commissioner, Trenton, N.J.

Eugene T. Urbaniak, chief, bureau of legal affairs, Trenton, N.J.

V. Terrell Davis, M.D., director, division of mental health, Trenton, N.J.

State department of health:

Marian R. Stanford, M.D., director, division of chronic illness control, 209 East State Street, Trenton, N.J.

Margaret H. Edwards, M.D., division of chronic illness control, 209 East State Street, Trenton, N.J.

Curtis E. Culp, M.D., division of constructive health, 209 East State Street, Trenton, N.J.

State department of education: Boyd E. Nelson, Ph. D., director of special education, 175 West State Street, Trenton, N.J.

Medical Society of New Jersey: Harrison F. English, M.D., 160 West State Street, Trenton, N.J.

State department of labor and industry:

Beatrice Holderman, director, New Jersey State Rehabilitation Commission, 38 South Clinton Avenue, Trenton, N.J.

Joseph A. Jordan, superintendent, New Jersey State Employment Service, Trenton Trust Building, 28 West State Street, Trenton, N.J.

Lawrence O. Houstoun, Jr., executive assistant to the commissioner, 20 West Front Street, Trenton, N.J.

New Jersey Hospital Association: Robert G. Boyd, director, Morristown Memorial Hospital, 100 Madison Avenue, Morristown, N.J.

New Jersey State Chamber of Commerce: Albert H. Acker, secretary, 54 Park Place, Newark, N.J.

Industrial Medical Association of New Jersey: Thomas F. Nevins, M.D., Esso Standard Oil Co., Bayway Refinery, Box 222, Linden, N.J.

New Jersey Association for Mental Health: Edward P. Duffy, M.D., 60 South Fullerton Avenue, Montclair, N.J.

New Jersey Neuro-Psychiatric Association: Eugene Revitch, M.D., New Jersey Diagnostic Center, Menlo Park, N.J.

Consultant:

New Jersey Consultation Service for Convulsive Disorders: James F. Ham-mill, M.D., 312 Briarcliff Road, West Englewood, N.J.

TEXT OF STATEMENT PRESENTED BY MR. PERCY L. CLARK, OTR, REPRESENTING THE NEW JERSEY OCCUPATIONAL THERAPY ASSOCIATION

Mr. Chairman and members of the committee, I am representing the New Jersey Occupational Therapy Association to speak in favor of the proposed independent living bill, H.R. 3465, as it relates to rehabilitation both in the fields of the physically handicapped and psychiatry.

The following are the urgent needs as we have experienced and recognized them as occupational therapists preparing patients to become more independent, responsible members of society.

(A) More sheltered workshops are needed: A job-placement service should be an integral part of the program to help shorten the time spent in the workshop.

1. One of the most urgent needs is that sheltered workshops accept the psychiatric patients who still require some supportive situation during the initial adjustment period in the community, and at the same time give him an opportunity to contribute to his own support.

2. We also must meet the need of those who cannot fit into competitive industry, such as those with progressive conditions who are not eligible under the present legislation, also those with multiple handicaps but who can attain some measure of self-support.

(B) More adequate professional services for the homebound who, with maintenance therapy administered in the home, could be productive in homebound employment of a limited nature.

(C) Halfway house type of facilities are needed for individuals without home or family, who could be discharged from a hospital, either with a residual physical handicap or on a convalescent status from a mental hospital, into a protective independent living situation.

Examples: The loneliness of feeling rejected by society, such as the psychiatric patient and the alcoholic; self-care problems of the physically handicapped requiring some assistance.

The required resident personnel would not need to be highly trained, thus not making it necessary to draw professionally trained personnel from more vital rehabilitation facilities.

(D) More generous provision for prosthetic devices, orthopedic equipment should be made for the needy individual to promote a greater degree of independent living.

(E) More adequate vocational counseling, evaluation, planning, and training services are needed for convalescing patients who are not presently eligible, especially in the psychiatric area which at present is inadequate.

(F) Counseling services must be extended to include families of the handicapped in cases where disability of the breadwinner necessitates a former dependent's assuming this role.

1. Counseling to help the family accept this shift in roles.

2. Vocational counseling and/or training for the new breadwinner may be needed.

(G) Greater numbers of professionally trained personnel are needed. This is the most serious, basic deficiency in meeting the needs of the rehabilitation program.

In occupational therapy alone there are job opportunities for 14,000 therapists in addition to the present 6,106 registered therapists. Also, enrollment in occupational therapy schools have decreased, due to high tuitions, which may mean that some of the schools will not be able to continue the curriculums.

1. Financial assistance is needed for extensive recruitment and publicity programs.

2. Financial assistance (tuition and living) should be made available for potential students as part of the recruitment program.

3. Scholarships for graduate work for registered occupational therapists would improve the quality of professional services.

4. Higher salaries are required to attract and keep greater numbers of personnel.

Mr. ELLIOTT. Our next witness is Mrs. Herbert Carson, president, National Organization for Mentally Ill Children, Philadelphia, Pa.

In the absence of Mrs. Carson, I shall next call Roger Davis, executive director of Goodwill Industries.

Is Mr. Robert F. Irwin, Jr., present?

Rev. Francis LeBlanco?

Dr. Ruth G. Arnold?

STATEMENT OF DR. RUTH G. ARNOLD, PROFESSOR OF SPEECH AND ENGLISH, JERSEY CITY STATE COLLEGE, NEW JERSEY

Dr. ARNOLD. Mr. Chairman, may I stand, please.

Mr. ELLIOTT. For the record, Dr. Arnold, would you care to state on whose behalf you are appearing today?

Dr. ARNOLD. Yes. I have a prepared statement which I would like to leave with you and highlight it with some remarks at this point.

I am presently assistant professor of speech and English at New Jersey State College, president of the State speech association, and have been a supervisor of speech for metropolitan public school system.

I think that in the presence of Dr. Kessler before we were all quite impressed with the very definite need that faces all of us in the field of training people for dealing with the handicapped and it is wonderful to be in the room in which that spirit still prevails.

Is it not strange that in a 20th century kind of civilization where we have choices about the kinds of cigarettes we buy, the automobiles that we buy, the perfume that we buy, et cetera, in a very material way and we have many, many choices, we do look for what a dollar can buy.

In the field of the education for the handicapped we do not really get our dollar's worth because we do not have any choices to make. In hiring candidates for the training of the handicapped, as I have had the opportunity of doing, it has been most difficult for me to hire or to find the person best qualified for the job that was available.

I think it has been established throughout yesterday's hearing and today that we do need additional personnel. Where do we get them from? Do we get them from the colleges and universities of the country? It would seem that that is probably the logical place. As Dr. School of Montclair has indicated, and others from other State teachers' colleges, we do not have the facilities or the finances to establish training programs.

Now, let me highlight from a rather personal point of view three findings which are included in my report. First of all, I had a part in conducting a statewide survey on the speech education needs of the State of New York in 1957. Some major findings there were that approximately 10,658 students were receiving some kind of speech therapy, some kind of speech correction.

These 10,658 students were being assisted by approximately 67 correctionists. With a little bit of mathematics and understanding that the national recommendation is 1 correctionist for at least 75 boys and girls, this would seem that in 1957 in an eastern seaboard State in the United States, one correctionist was working with approximately 159 students or, let us say, in round figures, twice the number that he actually should be working with.

Another finding of the survey was that of the 21 counties in New York note more than half had some kind of speech program. Now I would like to emphasize "some kind" because people still—and may I once again refer to Dr. Kessler—are still medieval in their thinking. They do not understand what we mean by educational speech correction. A speech to many laymen, to administrators, to teachers, means elocution, declaiming, public speech. It means, "Well, maybe we should have a speech program only if we have the money."

"Speech is a fad and a thrill. After all, you don't have too many handicapped people to worry about. Why get excited about this?" So there is a great deal of difficulty in conducting the survey throughout the State to get people to understand exactly what we were trying to discover, how many speech-handicapped people there were and what kind of training they were getting by how many people.

So of the 21 counties in New York only approximately 11 had some kind of program. If you do not wish to ask me other questions about the survey I would like to move along.

In this metropolitan area of Jersey City let us try to get a geographical view of the surrounding community of approximately West New York, North Bergen, Weehawken, North Hoboken, Union City, Bayonne, that out of these surrounding communities there is only one community in this metropolitan area, just across the river from New York City, that has any kind of ongoing speech program. In other words, this means a truly identifiable speech program for those who are handicapped, for those who are gifted, and for the normal child.

Now this seems to me to be a very important finding for all of us to keep in our thinking at the moment.

Mr. DANIELS. Where is that located?

Dr. ARNOLD. This community is Union City. The supervisor of speech for that community is in the audience this morning. This figure does not mean, or this picture does not mean that there are not children in the other communities who do not have problems; this is not so. Of course, they have problems. Where do these students go? Where do these frustrated parents go? Either to private people who are not particularly qualified or who have not the certification that a SHA testifies that a speech pathologist should have. So usually they do go to the National Hospital for Speech Disorders which is in New York City.

Thirdly, in my work at Jersey City State College I am only one person who is operating in a so-called speech clinic where all of the people who come to me, all of the telephone calls that come to my desk daily, I unfortunately must say, "I am sorry I cannot help you, we do not have the personnel, we do not have the facilities." Possibly with House Resolution 494 the time will come when my telephone answers will not have to be so abrupt.

In addition, at Jersey City we have very little inservice training for classroom teachers to assist in a stopgap kind of measure to help train those youngsters we may find in the regular classroom who have speech and hearing disorders.

Much can be done in an inservice way in this fashion to assist the classroom teacher but only sporadic attempts are being done at the moment. Again, at Jersey City, and this, of course, is very upsetting to me, it seems that we are accepting candidates for training in our teachers colleges who themselves have speech problems, who in no conscionable understanding should be placed in, let us say, an elementary school classroom if they themselves have speech problems.

Because we do not have the personnel we cannot do much with these candidates for teacher training. Finally, just to add a note to what has been said yesterday in regard to the special education program at Jersey City State in conjunction with the A. Harry Moore School, this is a splendid program, there is no doubt about it, but it certainly has not yet got off the ground.

There are no finances available for this, there are only two courses in the curriculum that are available now for young people interested in the field of special education to take at Jersey City. So the picture does seem rather black, does it not, when one verbalizes these things and in addition when one hears parents come to the clinic and say: "Well, don't bother about my boy, the doctor says he will grow out of this problem; he does not have a speech problem," again medieval thinking; this is not necessarily so.

My next question is, "Well, while we are waiting for him to grow out of the problem, how many other problems are going to arise?" Or the parent who comes in and says, "Well, my child has a cleft palate but that is the way the Lord made her and I am not going to do anything about it." So a great deal has to be done.

I heartily endorse your recommendation, members of the committee, and I should like to thank you very much for inviting me here. May I say that the first bit of homework assignment for some of the first recipients of your grants in aid to the various State pathologists be that they read the proceedings of this committee's hearings.

Mr. ELLIOTT. Thank you, Dr. Arnold for coming here today. Without objection, the written statement of Dr. Arnold will be filed for the record immediately following her oral testimony.

(The statement referred to follows:)

STATEMENT BY DR. RUTH G. ARNOLD, PROFESSOR, SPEECH AND ENGLISH, JERSEY CITY STATE COLLEGE, JERSEY CITY, N.J.

I should like to compliment the committee on its regional approach in assaying the needs for special education and the training of speech pathologists and audiologists in the United States.

Having been a supervisor of speech for a metropolitan public school system, and at present serving as assistant professor of speech and English at Jersey City State College, Jersey City, N.J., and president of the Speech Association of New Jersey, I should like to present some of my thoughts for your consideration.

First, it needs to be said that in the past many competent and dedicated men and women have worked in the field of speech rehabilitation—progress has been made, research has been accomplished, school systems are incorporating services for the speech and hearing handicapped—but the need still remains for more expertly trained speech pathologists—

To serve in more schools throughout the State;

To aid the growing numbers of boys and girls who have serious speech and hearing problems.

It is my contention, strongly felt on the basis of years of experience in school systems, in hospitals, and in private practice that, when more people know how to handle problems in both the fields of special education and the speech handicapped, the situation is likely to be helped because more parents, teachers, specialists in allied fields, and laymen will throw off their bonds of medieval thinking about the handicapped.

More damage is done to the child handicapped in any special way by well-intentioned meddling and by ignorance of the problem than by sheer neglect of the child with a crippling condition.

Daily I meet parents in the speech clinic at the college who say—

"My doctor says Johnny will grow out of his speech, hearing, or other problem."

"If the Lord gave Mary a cleft palate, she's got to bear it—we won't do anything about it."

"My child can't be mentally retarded—he just has something wrong with his speech."

"My boy just talks too fast; nothing's wrong with him that a good whack won't cure" (when in this case, the child is a severe stutterer).

"Oh, he don't talk because he was frightened by an animal; his tongue is stuck."

One would think these attitudes were those expressed by individuals not living in a communication oriented 20th century community. However, antiquated superstitions persist. Education and trained specialists are needed to get at the basic problems and to dispel the homespun diagnoses.

Let us survey the offerings in speech education in this local metropolitan area: Let us consider Jersey City of a focal point in the surrounding communities of: North Bergen, West New York, Weehawken, Union City, Hoboken, Guttenberg, and Secaucus.

Only one community, Union City, has an organized, ongoing, complete program of speech education offering speech correction, speech improvement, and speech arts. This does not signify that there aren't children with speech and hearing problems in the other communities. There are. It simply means that few funds are available for such special services and that too few members of boards of education and educators themselves have accepted the challenge in their midst.

Eventually in these communities parents of children having persistent problems have to be referred to or they go voluntarily to the National Hospital for Speech Disorders in New York City.

In fact, because I am working alone at Jersey City State College, I too have to make referrals to the National Hospital.

Respectfully, I should like to present one of the findings of the statewide survey of speech education which I conducted in 1957. It was printed in the *Speech Teacher*, a publication of the Speech Association of America. In 1957 it was found that approximately 10,658 children in the public schools of New Jersey were receiving some kind of speech therapy from 67 correctionists.

In other words on the average each correctionist was working with 159 children—a phenomenal figure in the light of its frustrating implications. The professionally recommended caseload for each correctionist is no more than 75 students. So in 1957 in the schools of an eastern seaboard State of the United States more than twice the suggested number of boys and girls needing speech and hearing therapy were handled by one correctionist.

My plea again is for more skillfully trained correctionists to serve in more schools throughout the State to aid the growing numbers of boys and girls who have speech or other special problems.

Further to sketch the existent problem—with which I am constantly faced at Jersey City State College, it can be stated that:

1. There is comparatively little service available for the speech handicapped individuals living in this city.

2. Only sporadic attempts are made at the State college to train classroom teachers to deal with children handicapped in speech in the regular classroom.

3. There is little service available for those Jersey City State College students, training to become teachers, who have speech problems themselves to get the help they need. Shall we compound the felony, as it were, by permitting a teacher handicapped in speech to serve as the speech model for a class, especially on the elementary school level?

Though our six State colleges are to varying degrees preparing speech correctionists and special education teachers, the number of qualified personnel being trained are not sufficient for the needs at present. Though we've come a long way since the practices of incarcerating the mentally deficient in the attic, or cutting off portions of the tongue to alleviate stuttering, nevertheless, the handicapped in many places still suffer from lack of therapy and from the ridicule of family, friends, and society.

It is time that we worked with all those who are handicapped on a more complete basis. That is, speech therapy, physical rehabilitation, public or private schooling, emotional rehabilitation, occupational guidance, all disciplines should proceed in unison in terms of the needs of the individual.

When the specialist in each of these disciplines is working alone, he, in large measure, defeats his own purposes. Since the human body is such an intricate interrelated organism, handicaps in any one or more of its parts affect most assuredly other of its parts. In many cases, for example, a child's speech defect is symptomatic of other ills: emotional, mental, psychological, or physical. Merely correcting or alleviating the speech defect is a temporary measure. The cause of the speech problem needs to be discovered and eliminated (if possible) first.

Such a total approach in working with the speech handicapped, can best be achieved by recruiting the best qualified candidates from undergraduate college and university levels and by training them in terms of professional graduate courses. A plea is entered at this point for upgrading the basic standards of speech pathologists; that membership in ASHA be mandatory; that before one is permitted to specialize in speech pathology that he successfully complete at least a year of regular classroom teaching.

It is therefore urged that House Joint Resolution 494 be passed to provide for more expertly trained speech pathologists and audiologists—

To serve in more schools throughout this State and the country;

To aid the 8 million Americans handicapped in speech and hearing.

[Reprint from the *Speech Teacher*]

SPEECH EDUCATION IN NEW JERSEY: A STATEWIDE SURVEY

(By Arthur A. Eisenstadt and Ruth G. Arnold¹)

A survey of the speech offerings in the public schools of New Jersey has long been needed to discover the present scope of speech education in the State and the trends of its growth. Such a survey would identify those areas already having successful speech programs and serve to encourage administrators, members of boards of education, teachers, and leaders in other communities (both within and outside the State) to plan for the development of speech programs in their respective school systems. For these reasons we undertook the survey we describe below.

To each of the 21 county superintendents of schools we sent an explanatory letter and a questionnaire. We asked each superintendent to supply as much information as he could concerning the existence and extent of the speech program in his county. In the questionnaire we suggested that if in each of the cities or townships there were some key persons who could give us more detailed information that the superintendent supply us with the name and address of the teacher or administrator who could best answer the questionnaire.

Each of the 21 recipients returned the questionnaire he had received, either having answered it or indicating the person who might be better able to supply the data we had requested.

The county superintendents suggested a total of 45 names to us. These individuals were mostly residents of the larger metropolitan areas of the State, in Essex, Hudson, Passaic, Union, and Bergen Counties. We sent a more detailed questionnaire to these 45 teachers and administrators, requesting information in five different and distinct areas. From these 45 questionnaires we learned the names of 19 key people throughout the State who had direct experience with the speech programs in their schools. To these 19 we sent a letter concerning the purpose and nature of the survey and the detailed questionnaire.

From 16 of these 19 people we received replies to our requests for data. We base our findings on these 16 answers to the detailed questionnaire. In all, we queried 88 individuals throughout the State, not once, but several times, during the survey in order to verify the data we collected.

All of the 21 counties of New Jersey, from Atlantic to Warren, were included in the survey. To date, in 11 of the 21 counties there is no established program in speech. However, superintendents in several of these counties expressed the hope that in the near future there might be some consideration of the speech needs of students in their localities.

According to the reports we received, the greatest concentration of work in speech and the largest number of teachers of speech are in the metropolitan area. Essex County has 20 full-time teachers; Hudson County has 16 full-time teachers and 1 part-time teacher; Passaic County has 13 full-time teachers; Union County has 10 full-time teachers and 1 part-time teacher; Bergen County has 8 full-time teachers of speech.

Approximately 10,658 children are receiving speech therapy, under 67² correctionists. The correctionists see pupils once a week, on the average; from only one school did we receive a report of a therapist's meeting with pupils twice a week.

¹ Readers of the *Speech Teacher* are familiar with the name of the senior author of this report because of earlier publications in the *Speech Teacher*. His "As Others See Us" appeared in the issue for March 1952; "Speech Education Survey of New Jersey Junior Colleges," in November 1953; and "The Role of Speech in the New Jersey School Program," in November 1956. Dr. Eisenstadt is a consultant in speech correction for the Department of Special Education, Newark Board of Education, and University College, Rutgers University. He also has a private speech practice in Montclair.

The junior author has not previously written for the *Speech Teacher*. Currently an assistant professor of speech at the State Teachers College at Jersey City, at the time of making the survey Mrs. Arnold was supervisor of speech for the Union City [New Jersey] public schools. She received her B.A. degree from the New Jersey State Teachers College at Montclair and her A.M. and Ed. D. degrees from Teachers College, Columbia University, in 1940, 1945, and 1954, respectively.

² This number does not include those correctionists working with private agencies who also serve the schools in their areas. In at least six areas of the State there are tentative plans for the employment of additional correctionists in the near future.

The number of children participating in speech improvement³ programs ranges from approximately 1 percent of the school population to 20 percent; in some instances it is as high as 100 percent. Those schools that do include speech improvement in their speech programs do so according to a variety of plans. In 11 systems the speech improvement program is in the high school; 8 school systems present speech improvement in the elementary school; in 7 systems it is part of the English program throughout the schools; in 8, speech improvement is a separate course; in 6 it is elective, and in 3, required. However, because of semantic confusion among some of the respondents concerning "speech," "English work," "communication," "oral English," and similar terms, we could not ascertain the total number of English and other classroom teachers engaged in teaching various speech skills. The teachers of speech improvement per se total 25.

There was no clear indication of the number of children participating in classes in speech arts. In general, where speech is available in a school, the traditional emphasis is on dramatic arts. In general, activities in the speech arts are available to the gifted few; no respondent reported a school system in which speech arts are accessible to all students. According to this survey, 86 teachers of speech arts are employed in the State.

So far as we can determine, there are approximately 561 students with hearing handicaps. We do not present this figure as an exact finding, however; it is merely a byproduct of the survey as those who may have been in a position to present valid information relayed it to us.

The oldest known program in the State that this survey revealed is Jersey City's, established in 1918. In the 1930's there was a noticeable surge of new programs. In the 1950's there was another period of increase in the number of speech programs. The greatest amount of activity at present seems to be in the field of speech correction. Speech arts, in most instances as elective courses, receive the next greatest amount of emphasis, with least emphasis on speech improvement. There were reports from only two schools of significant growth in each of the three areas of speech correction, speech improvement, and speech arts.

The replies from the 16 areas throughout the State indicate that in 11 school systems there is a provision for screening all pupils to discover speech problems. In four systems there is no overall screening. (One respondent did not reply to this question. In seven school systems the correctionist in charge conducts the screening. Four systems utilize referrals. In one school tape recordings are made of all the pupils' voices. In most of the systems the tape recorder and the pure-tone audiometer are regarded as indispensable tools for diagnosis and therapy.

As one of us has reported elsewhere,⁴ the team concept is growing in the New Jersey school systems. Specialists in various areas pertinent to the growing child and his problems are appearing in the schools in greater numbers and with increasing frequency. For instance, there are not only school nurses, but also school physicians in all the 16 systems represented in this survey. All but one of the systems employ a school psychologist, and in 12 there is a school dentist. It is perhaps indicative of the direction of the growth of special services that school psychologists outnumber school dentists. Five systems have added social workers to their staff. This addition of special personnel suggests the administrative view that truancy and behavior problems may be due to the pupils' homes and social backgrounds—a view which teachers of speech have long utilized in their therapeutic programs. Other additions to the special services (and "special" is fast becoming inaccurate and obsolete in this context) are those of otologists. At present four school communities utilize otologists to facilitate the diagnosis and proper placement of pupils with hearing losses and allied speech disorders. This varied array of specialists suggests that speech education in New Jersey is based on the "whole child" concept.

³ By "speech improvement" we mean basic instruction in the fundamentals of speech: voice, diction, simple public speaking, listening, conversation, telephoning, and interviewing.

⁴ Arthur A. Eisenstadt, "Selected New Jersey Sources of Interest to the Speech Correctionist" (Newark: Division of Special Education, 1956).

The respondents report 12 different textbooks⁵ in use in the 16 school systems. These books represent two clearly discernible areas of emphasis, one on speech improvement, the other on speech arts. The two emphases seem to be approximately equal. In Newark schools there are two separate speech textbooks, one for speech correction, the other for speech skills in social situations. This wide range of textbooks is further evidence of the divergence in the philosophical approach to speech education, in the proportional stress on various facets of speech training, and, ultimately, in the very goals and purposes of the speech programs in the schools of New Jersey. It was to this last factor that we next directed our attention.

According to the respondents, in 11 school systems the primary goal of the speech program is speech correction for handicapped pupils, with speech improvement for all pupils as a major goal. In four systems training in the speech arts is the present goal, with the implication that there will eventually be an increase in the amount of training in the speech arts. Two respondents reported that developing the pupils' poise and confidence is the goal of the speech programs in their schools. Another pair stated the aim of their programs was to provide the students with an understanding of speech planning and organization. The following statements are revealing:

"To help the child to express his own thoughts, needs, and desires * * * with distinction [sic] and clarity.

"The correct production and natural presentation of sounds, words, and ideas.

"Speech correction and speech improvement for all who need it.

"Better communication skills and greater personal enrichment for all the pupils we can reach."

It is quite understandable and inevitable that quite different methods should develop in different communities. Both the varying needs of the school populations of widely separated areas and the differing backgrounds and ideologies of the teachers insure a disparity of approaches. In many respects it is fitting and proper that there should be variation and adaptation to local conditions. Further, such wide divergence among these communities, particularly those which are ethnically, pedagogically, and socioeconomically substantially different, bespeaks both independence and flexibility. Nevertheless, so much difference, especially when it extends to the virtual exclusion or omission of certain goals and areas of speech education leads one to wonder if a more inclusive and widely consistent pattern of speech education (perhaps with the common core curriculum philosophy as its foundation) might not lead to a more nearly uniform and effective teaching program.

On the basis of the data the questionnaire elicited, certain directional patterns of growth seem to be identifiable, and it is possible to make several apparently tenable observations. First, instruction in speech (in the specialized teacher sense of the term) is assuming substantial proportions in New Jersey. There are apparently four major divisions of this instruction: speech correction, speech improvement, communication skills (public speaking, group discussion, and debate), and speech arts (e.g., oral interpretation, dramatics, and choral speaking). Within these divisions, speech education in New Jersey, which began on an organized systemwide basis as long ago as 1918, is expanding rapidly. In the last decade the number of communities engaging speech specialists has almost

⁵ Alphabetically by author(s) they are as follows:

Louise Abney and Dorothy Miniace, "This Way to Better Speech" (Yonkers, New York: World Book Co., 1940).

Alice Evelyn Craig, "The Speech Arts: A Textbook of Oral English" (second rev. ed.; New York: the Macmillan Co., 1941).

E. F. Elson and Alberta Peck, "The Art of Speaking" (Boston: Ginn & Co., 1952).

Francis J. Griffith, Catherine Nelson, and Edward Stasheff, "Your Speech" (New York: Harcourt, Brace & Co., 1955).

Wilhelmina G. Hedde and William Norwood Brigance, "American Speech" (Philadelphia: J. B. Lippincott Co., 1955).

Grace A. McCullough, "Work and Practice Book for Speech Improvement" (Boston: Expression Co., 1940).

Letitia Raubicheek, "Speech Improvement" (New York: Prentice-Hall, Inc., 1952).

Lew Sarett, William Trufant Foster, and James H. McBurney, "Speech: A High School Course" (Boston: Houghton Mifflin Co., 1943).

Lucille D. Schoolfield, "Better Speech and Better Reading: A Practice Book" (Boston: Expression Co., 1937).

Louise Binder Scott and J. J. Thompson, "Speech Ways" (St. Louis: Webster Publishing Co., 1955).

—, "Talking Time" (St. Louis: Webster Publishing Co., 1951).

Clara B. Stoddard, "Sounds for Little Folks" (Boston: Expression Co., 1940).

doubled, and there are many indications that more communities throughout the State are planning to develop either new or more extensive speech programs.

Further, there is a change in the emphasis on various phases of speech education. Traditionally, the speech arts, particularly dramatics and declamation, have received the greatest amount of attention. While class plays and the oral reading of poetry continue to play a justly important part in activities for creative expression, the trend seems to be toward a constantly growing emphasis on speech correction. Although respondents reported little increase in instruction in speech improvement, some of them expressed the opinion that there is a definite need for such an increase. Where radio speaking, debate, discussion, dramatics, or participation in assembly programs are available to pupils, they are typically part of the English program, or are extracurricular activities.

The concept of speech education is evolving. Opinions concerning the extent to which entire classes, rather than selected individuals, shall receive speech instruction are changing, involving the issue of classroom versus clinic training. The use of a literary or general diction approach in contrast to dealing with a single sound or specific speech defect per se is undergoing scrutiny and reevaluation. Attitudes toward specialty training and teacher background are also changing. Apparently there is an increasing number of specialists whose education includes a broad coverage of the total speech spectrum: Arts, science, crafts, and related subjects. This circumstance suggests that it will become possible to employ the services of specialists whose training in and perspective of other areas are sufficiently broad for them to aid in the integrative goals of general education.

In summary, then, the speech program in New Jersey is vigorous, and is making rapid strides forward. Its overall speech picture compares quite favorably with those of other States, and is definitely improving. We have by no means reached the point which we can and should attain, and, woefully, many communities are as yet entirely without a speech program. But we can justifiably point to our professional growth with pride and gratification.

EXCURSUS

"Rule.—Before attempting to read a lesson, the learner should make himself fully acquainted with the subject, as treated of in that lesson, and endeavor to make his own the feelings and sentiments of the writer.

"For this purpose, every lesson should be well studied beforehand, and no scholar should be permitted to attempt to read any thing, which he cannot easily understand. When he has thus identified himself with the author, he has the substance of all rules in his own breast. It is by going to nature that we find rules. The child or the savage orator, never mistakes in inflection, or emphasis, or modulation. The best speakers and readers are those who follow the impulse of nature as felt in their own hearts, or most closely imitate it as observed in others. As the first and most important step, then, let the reader or speaker enter deeply into the feelings and sentiments, which he is about to express in the language of another. This direction is placed at the threshold of this subject, because the prevailing fault in reading is listlessness and dullness, and the principal cause of this fault, is want of interest in the subject which is or ought to be before, the mind."—William H. McGuffey, *"McGuffey's Newly Revised Eclectic Fourth Reader: Containing Elegant Extracts in Prose and Poetry, With Rules for Reading, and Exercises in Articulation, Defining, etc."* (Cincinnati: Winthrop B. Smith & Co., 1853), pages 7-8.

Mr. DANIELS. When was this study completed that you spoke about?

Dr. ARNOLD. 1957 and 1958.

Mr. DANIELS. This was given to the State Legislature of New Jersey, and you have appeared before them?

Dr. ARNOLD. The department of education, not the legislature.

Mr. DANIELS. Not the legislature?

Dr. ARNOLD. No.

Mr. DANIELS. Has any bill been introduced in the legislature to bring more aid?

Dr. ARNOLD. No.

Mr. DANIEL. Thank you very much, Dr. Arnold.

Dr. ARNOLD. You are welcome.

Mr. DANIELS. Our next witness will be Dr. Maurice C. Kott, acting director, division of mental retardation, Department of Institutions and Agencies of Trenton, N.J.

Dr. KOTT. I have a written statement which I will file with your clerk. I think if I ad lib from it, or read from it, I can bring it within a few minutes.

Mr. DANIELS. You have 10 minutes.

Dr. KOTT. I will make it, sir.

STATEMENT OF DR. MAURICE G. KOTT, ACTING DIRECTOR, DIVISION OF MENTAL RETARDATION, NEW JERSEY DEPARTMENT OF INSTITUTIONS AND AGENCIES

Dr. KOTT. I am grateful for this opportunity to appear before the committee.

The areas of your concern are vital to all citizens and action by the Congress of the United States of direct import to the programs for retarded and other handicapped persons in the State of New Jersey.

In this statement I wish to make reference to two problems, both the concern of this subcommittee. The first problem involves unmet needs in programs of special education; the second problem involves rehabilitation services to handicapped individuals with the possibility that as a result there can be dispensed with the need for expensive institutional care.

This committee undoubtedly has heard much testimony on urgent needs in special education. Representatives of the New Jersey State Department of Education have offered you facts on the extent to which comparatively new programs in the State are effective.

As in all areas of governmental operations, the enactment of a statute providing types of special education does not guarantee a supply of personnel to implement the purposes or to execute the intent of the statute.

Experience in New Jersey since 1954 has disclosed a shortage of qualified personnel to teach handicapped children; even more critical is a shortage of supervisory, administrative, and research personnel to establish goals and methods of attaining objectives and to insure steady progress toward such established goals or objectives.

These New Jersey experiences of lack of personnel are not unique. They are replicated throughout the country.

That needs for teachers and supervisory personnel have persisted for many years may be somewhat surprising in view of the many attempts to attract qualified personnel to the field.

The Federal Government has enacted statutes to aid the education of blind and other kinds of the handicapped. Federal funds have been available for scholarships and for research in appropriate areas.

This committee is presently considering a resolution to help make scholarships available for training of specialists to assist children with speech and hearing impediments.

There has also been alteration in social values relating to this kind of work.

The influence of organizations like the National Association for Retarded Children and the National Organization for Mentally Ill Children has been great. Work with persons that are the immediate concern of such associations is considered significant, appropriate, and sometimes even noble.

Yet shiny novel programs, Federal aid, and new social values have failed to attract sufficient personnel to meet the educational needs of the handicapped.

Of significance in the matter of shortage of qualified personnel in the area of special education is the persistent shortage of teachers in all kinds of educational programs. School systems have difficulty in recruiting qualified personnel and are forced to employ comparatively large numbers of teachers with less than standard certification.

This problem has persisted despite some expansion of college size, increased recruitment activities, and extension and inservice programs to upgrade teachers with substandard certificates.

Even marked salary increase and greater fringe benefits have been of little avail in attracting great numbers of persons to this field.

It should be noted that this situation is not unique to education. Manpower trends in the mental-health professions show tendencies to short supply in the face of increasing demand.

A congressional inquiry on mental illness in 1953 saw a need for twice as many psychiatrists as were then available. It is estimated that there is a national gain of but 450 psychiatrists a year and that it will be 20 years before there will be double the 1953 number in the country.

Of course, as our population grows in the next 20 years, the need will grow, too. We will remain short of this class of professional.

Further, medical schools have been faced with a low-tide manpower pool. In recent years such schools have accepted a higher and higher proportion of applicants.

In 1948-49 the ratio of applicants to admissions was 3.6 to 1.

By 1953-54 it dropped to 1.97 to 1, and by 1954-55 to 1.87 to 1.

In psychology, the output of universities has remained somewhat more static than the demand.

Moreover, in the presence of a drop in number of bachelor degrees in psychology in recent years, the number of graduate-school enrollments for training in psychology will also drop.

As far as social work is concerned, there are signs of a growing shortage in this field. There is some evidence that some schools are operating below capacity and that a high proportion of members of the profession leave the field, for instance, to become homemakers.

Extension or inservice programs do little to meet demand since most persons taking such courses are already in the field of social work.

This pessimistic yet realistic recital of the general shortage of workers in the areas of education and mental health suggests that no limited or simple approach will provide a solution to this problem in special education. Some massive effort must be undertaken to assure educational opportunities and training to all who are intellectually qualified.

A large percentage of students capable of work in these areas drop out before completing high school. Of those who complete high

school, many do not undertake collegiate training and some who begin college do not finish.

There is evidence available that of the upper 20 percent—in terms of intelligence—only one-third finish college.

The current financial attractions of industry and commerce dilute the pool of college aspirants.

The rumors of difficulty in admission in the face of a closing door to college may dissuade some potential students. And the general American attitude about the collegiate-trained egghead who is impractical in dealing with realistic and financial matters, may have a large influence on all who might be capable of collegiate training.

What seems to be called for is an extended effort to make the professions as financially attractive as other forms of adult work, so that all who may be intellectually capable desire to go on to college. This making attractive may have to include not only scholarships but forms of subsidization during those years that the college student is precluded from earning the equivalent of that earned by the high school student who does not go to college.

Of course, some national action is required to make certain that colleges and universities do have space for an expanded student body. Federal support is necessary to expand college size and to expand faculty so that the quality of instruction or training remain high.

The second problem to which I desire to address myself is engendered by the aspirations for the independent living bill—H.R. 3465. This bill makes certain assumptions which are open to question.

Two seem worthy of comment. The assumption that it is generally desirable to “dispense with expensive institutional care” and the assumption that the skills of a rehabilitation counselor, as we now know of the training and achievements of such persons, are sufficient to accomplish the objective sought by this bill.

Dispensation with institutional care—without regard to the matter of expense—is an aspiration to be considered with caution.

While in the past there was overemphasis of the value of rehabilitation services, at present the institution has been placed in balance with other rehabilitative forces.

In many States its use is reserved for those cases which cannot be handled in the community. Institutions for the retarded, for instance, have noted a change in type and age of persons committed.

The mildly retarded, educable adolescent, or young adult, has become less evident in their populations. Received in institutions, presently, are those who are antisocial, who are dependent or neglected children, without homes, or who are so severely handicapped that they cannot be given care in their own homes, or cannot be given the care they require without severely disorganizing family life.

The institution provides for these a balance of a growth promoting and custodial arrangements not readily conceived as possible in an independent living situation.

For any handicapped person, a good institution provides an opportunity for development in a protective environment and for opportunities of social and vocational failure without the adverse effects which frequently attend failure in the community.

To dispose of values of institutional care because of expense may be a reenforcement of financial rather than human values, a general trend that may do the handicapped much disadvantage.

To be sure, institution residence may develop other kinds of disadvantages for the handicapped. The way to deal with this, however, is to correct whatever faults there may be in institutions and not dispense with the advantages inherent in institutional programs.

Even should one wish to beg the question of the comparative advantages to be derived in independent living, over institution care, supervision and services in this proposed program is in the traditional competence of the social worker rather than the rehabilitation counselor.

Indeed, institutional social workers do provide, where they are available, such services in pre- and post-institutional programs.

Further, it is noted that in H.R. 3465, there is provided for "co-operation" between the State rehabilitation agency and the State and local agencies administering various public assistance, insurance, and public health services. If expansion of the social-work services of these agencies is desired, why not provide for Federal assistance directly to these agencies for expanded case work programs rather than depend upon the development of a new tradition and new service and upon cooperation with other State and local agencies.

One last point: if the argument about low-tide manpower pools is cogent, from where are the personnel for this new service to come? If they are to be rehabilitation counselors, they may be taken from the thin ranks of potential teachers or other needed personnel.

If they are to be social workers, what is to happen to the present, desirable welfare programs suffering from a short supply of trained workers.

Even in regard to the independent living bill, some direct extensive effort at extending educational opportunities by scholarships and subsidization is necessary.

Again I would like to express my appreciation for the opportunity to appear here and to announce that I shall be happy to try to answer what questions you may have, sir.

MR. DANIELS. Are there any questions, Mr. Chairman?

MR. ELLIOTT. No.

MR. DANIELS. Thank you, Dr. Kott, for your testimony this morning. It will be of great help to this committee.

DR. KOTT. Thank you, sir.

MR. DANIELS. Dr. Anthony B. Suraci.

You are the head of the department of education for teaching handicapped, Seton Hall University?

DR. SURACI. That is correct.

MR. DANIELS. Mr. Suraci, I shall limit you, as I have all the other witnesses, to 10 minutes.

If you have a written statement, I might suggest to you that you summarize your views and your written statement will follow your oral testimony in the record, or you may read directly from the statement.

However, the time limitation will be imposed because of the large number of witnesses who desire to testify.

**STATEMENT OF DR. ANTHONY B. SURACI, HEAD, DEPARTMENT OF
EDUCATION FOR TEACHING THE HANDICAPPED, SETON HALL
UNIVERSITY, SOUTH ORANGE, N.J.**

Dr. SURACI. I do not have a written statement, Mr. Daniels. I just have a few notes available for presentation.

I would like to express my appreciation to Mr. Elliott and the other Members of the House of Representatives for providing me with the opportunity to present my views as I see them in regard to the needs of special education.

We feel that if the needs of special education are to be met adequately, that Federal moneys should be made available to both State, local organizations, communities, private institutions, and so on.

In order to save some of the following needs:

The first one of primary importance as we see it is the need of extending aid to the smaller colleges and universities in order to promote their programs of special education.

To do this it is necessary to improve library facilities, more instructional equipments, and materials; to extend the programs, that is, the actual courses offered; to extend educational and medical research, to initiate and/or to expand fellowship programs and scholarship programs, and, finally, to extend clinical programs.

Seton Hall has offered a program in special education since 1954. Since that time a number of graduate students have been matriculated and are now teaching in special education in the State of New Jersey.

We have approximately 150 students at this time who are either working for State certification to teach the handicapped, or are matriculating for a master's degree in education with specialization to teach the handicapped.

Seton Hall is unique in that it is the only university in New Jersey which has, as part of its faculty, a medical school.

In addition a working relationship has been established this year with a number of public and private agencies throughout the State, centers such as the Kessler Institute, the New Jersey Commission for the Blind, the Mount Carmel Guild, the public schools in Newark, West Orange, East Orange, and so on.

It was felt that by developing this relationship we would better be able to utilize all of the resources available. With these facilities it would then become possible to promote realistic research in the field of education.

I am thinking in terms of the best programs, equipments, methods, and so on, with which to assist the handicapped.

The next point that I would like to make is in regard to the recruitment of personnel in special education. We feel that if a sound scholarship program were offered we would be able to attract a larger number of highly capable people into the field of special education. In terms of the program at Seton Hall, if a number of scholarships of about \$400 could be granted to people who are working for State certification and about \$800 to students who are planning to matriculate for the master's degree in special education that the caliber of student who would be interested would be extremely high.

Mr. DANIELS. Mr. Suraci, at this point may I ask you a question? From your experience, have you a sufficient number of recruits who are interested in taking a course in special education?

Dr. SURACI. As indicated by the increase in the size of the student population, yes. Where in 1954 it started off with approximately 10 students, now we have 150 students.

Mr. DANIELS. What are the chances of their being employed immediately upon graduation?

Dr. SURACI. To date all of our graduates have been employed in New Jersey. Further, I do have a number of vacancies in our employment placement bureau which we have been unable to fill at this time because of the demand for teachers in special education.

Mr. DANIELS. Have any of these students refused to accept employment because of the fact that the compensation is inadequate?

Dr. SURACI. Well, I would rather say that they have given preference to communities which have a relatively good program of special education and this in turn is supported by the community's ability to pay.

Mr. DANIELS. Perhaps I should have rephrased it. Do you know of any cases of your student graduates who have abandoned their career, so to speak, in the field of special education, because of their inadequacy of the salaries that have been offered?

Dr. SURACI. Yes, I do; not only at the teaching level, but at the supervisory level.

The gentleman that I have in mind has currently left the field of special education to go into insurance because he could not afford to stay in it.

Mr. DANIELS. You feel, therefore, that the salaries should be higher than the average teacher's salary?

Dr. SURACI. Yes, I do; I think there are many others who share this viewpoint as indicated by an article in the 49th Yearbook of the National Education Association.

I have a few other needs which we feel are pressing. I will not do other than to indicate them as a need.

First, the need for a continuous census in order to identify as soon as possible those children who are handicapped so that the best types of educational provisions can be made. The need for more facilities, physical plants, and equipment for educational and training purposes.

Of great importance is the need for further community relations programs, for public information to develop a greater public awareness and public support of programs in special education. There is a need for extensive parent and/or family counseling programs because of the effects which handicapped children place on the family. There is a need for additional diagnostic centers. There is a need for further institutional facilities for those who are more severely involved.

In regard to the institutional program we are thinking in terms of halfway houses, which is the type of residential school between the community and the institution where students may return to in the evening, be employed and participate in community living.

In other words, it is a halfway step between institution and the community.

In conclusion I would like to say with the wealth of this Nation it would seem that money could be made available to promote the causes of special education, not only from the humanitarian point of view, but from a practical point of view.

We know that without education and training these children frequently become liabilities to the families and to the taxpayers, but with proper education and training they may become useful contributing members of society.

Thank you.

Mr. DANIEL. Thank you.

Are there any question, Mr. Chairman?

Mr. QUIE. How big is Seton Hall University.

Dr. SURACI. We have approximately 9,000 students.

Mr. QUIE. You say you train teachers of the handicapped. Which handicapped are you training teachers for?

Dr. SURACI. We train teachers for the area of the mentally retarded, the deaf and hard of hearing, the speech handicapped, the physically handicapped, and emotionally disturbed. Our program in the area of mental retardation is the largest phase of it.

Mr. QUIE. I understood, from your testimony, that we would need more colleges providing training for teachers of the handicapped than we presently have.

Dr. SURACI. I am sorry if I gave that impression. I meant that we have a number of smaller colleges and universities in the United States who are offering a program, but for reasons—well, at least in our point of view—financial reasons, they are unable to expand on the points which we have mentioned.

Mr. QUIE. So the ones who are presently providing the training would like to expand?

Dr. SURACI. Yes.

Mr. QUIE. Are you going to have difficulty, if we do provide funds, to expand the program to find teachers to train the teachers?

Dr. SURACI. This is a point which must be considered. I think that with financial assistance we will be able to attract a strong faculty.

Mr. QUIE. That will take a little time, will it not?

Dr. SURACI. Yes, it will.

Mr. DANIELS. What period of time has this program of special education been in existence at Seton Hall?

Dr. SURACI. Since 1954.

Mr. DANIELS. Am I correct in understanding your testimony that you have 150 trainees?

Dr. SURACI. That is correct.

Mr. DANIELS. What are the prospects of enlarging that in the future?

Dr. SURACI. Quite good, if the increase in enrollment in the last year is an indication. It is quite good.

Last year we had between 80 and 90 students who were doing work in special education.

Mr. DANIELS. Is it your thought that with the aid of grants or fellowships by the Government, the Federal Government, that other students would be encouraged into this field?

Dr. SURACI. Very definitely.

Mr. DANIELS. Thank you very much, Mr. Suraci, for your testimony.

Dr. BARNARD. Mr. Chairman, I would like to request that the telegram just received from Mr. C. L. Eby, director of the bureau of vocational rehabilitation, be made a part of the record at this point.

Mr. DANIELS. Without objection, it may be entered in the record.
(The telegram referred to follows:)

HARRISBURG, PA., February 19, 1960.

HON. CARL ELLIOTT,
(Attention, congressional hearings, Jersey City, N.J.):

I sincerely regret that my air transportation has been canceled and trains delayed. I will be unable to appear at the hearing scheduled for 2:20 p.m., Friday, February 19. I wish to compliment you and your staff for the manner in which the workshops were conducted and in providing an opportunity to appear before your subcommittee. Pennsylvania urgently requests that you report favorably on H.R. 3465. The passage of this legislation will create jointure of force between the medical profession, all rehabilitation facilities, workshops, and State rehabilitation divisions that will enable handicapped residents of Pennsylvania to be useful citizens.

Dr. Dice officially represented the Governor. She should have testified that the general assembly passed and the Governor approved the providing of service to the severely handicapped to achieve the ability of independent living, providing Congress amends the National Rehabilitation Act and appropriates the Federal matching funds.

C. L. EBY,
Director, Bureau of Vocational Rehabilitation.

Mr. DANIELS. Mrs. Herbert Carson, president, National Organization for Mentally Ill Children, Philadelphia, Pa.

Mrs. Carson, undoubtedly you have heard me limiting the other witnesses to 10 minutes in testimony.

Mrs. CARSON. Yes, sir.

Mr. DANIELS. The same limitation will be imposed on you.

STATEMENT OF MRS. HERBERT CARSON, PRESIDENT, NATIONAL ORGANIZATION FOR MENTALLY ILL CHILDREN, PHILADELPHIA, PA.

(The formal statement of Mrs. Carson follows:)

STATEMENT OF MRS. HERBERT CARSON

The National Organization for Mentally Ill Children, the organization I represent, finds in bill H.R. 3465 much that is encouraging. One most commendable provision is the concept that includes "mentally ill" under the term "handicapped."

We in Pennsylvania have long sought to have the emotionally disturbed and mentally ill included in the all-embracing term "handicapped." A case in point is the campaign we waged to have the Pennsylvania educational law revised so that emotionally disturbed children would be included under the law which provides special education for all other handicapped children. In spite of our vigorous efforts, the law still excludes these children from such aid.

Here are a few statistics to point up the urgent need for special education. At the present time approximately 60 percent of Pennsylvania's handicapped children are receiving educational support. Unfortunately, as indicated, "handicapped" does not include emotionally disturbed children. The number of such disturbed children is tragically high. It has been estimated that 10 to 15 percent of the present classroom population requires help with emotional difficulties. If such help in the school system is unavailable, what now are minor problems can grow into major ones.

Outside of the school system such agencies as mental health and child guidance centers attempt to grapple with the problems. Unfortunately, such supplementary services are few. But even if they were more plentiful, they would still provide but a small part of the continual and intensive help that the seriously disturbed youngster requires. Such psychiatric and psychotherapeutic treatment on an individual basis, should be ancillary to a full and rich school program. Emotionally disturbed children, then, should be included under the umbrella term "handicapped children."

The long-range implication of the above becomes even more discouraging in light of the population increase expected by 1970. It is clear that the magnitude of the problem of planning mental health services for children far exceeds both present resources and the attention that has been given it.

What of the child whose condition requires a controlled environment away from home? What is the alternative for the family which can neither afford nor find placement? The State hospital is a last desperate resource: With a guilty feeling that he is abandoning his child, the parent is forced to make this decision. This feeling is based on current public attitudes toward mental hospitals as well as the parent's awareness of existing conditions. What future can we expect for the seriously disturbed child in a crowded setting with little better than custodial care? The time has come to stop thinking of our mental hospitals as dumping grounds for incurable cases, and to begin orienting them toward returning the child to the family and community. If this is our objective, as it must be, then we must seriously consider and face the necessity of keeping the residential center physically within the community and of providing an educational and therapeutic program which will be constructive and beneficial.

If inpatient services are to be oriented toward returning the child to the community, we must face the overwhelming need for facilities to help the child make the transition back to the home and to stay there. Obviously, adequate day care centers could remove a considerable number of children from the hospitals and residential centers. Children who could benefit from remaining with their families are often prevented from staying with them because of a lack of a specialized group setting in the community. To meet this need, Valley Day School was set up in Bucks County as a demonstration day center geared to therapeutic education. The children admitted include schizophrenic and autistic children who had previously been excluded from public and private schools. The aim of the program is to reach the child and then to teach him. Even his fears and fantasies can be used as a bridge to reality and to academic learning. Results to date have been encouraging. Such centers, however, are pitifully few and the burden of keeping them alive with private funds threatens their very existence.

Many of the children now exempt from the public school system can utilize a specially designed school setting within the public school.

In Pennsylvania we have even less advantages than some of our neighboring States which have enacted legislation providing for special education even though in some cases such legislation may be no more than declaration of public policy. We have been blocked in our efforts to establish facilities for special education, as we pointed out at the beginning of this testimony, by the basic failure to interpret the term "handicap" to include mental illness and emotional disturbance along with mental retardation and physical limitation.

It is obvious that in this field of special education, as in regular education, the States need the encouragement of appropriate and meaningful Federal action. Therefore, we respectfully submit that these are the responsibilities of the Federal Government:

- (1) To encourage legislation on State levels to include select mentally ill children now deprived of a free education.

- (2) To develop and disseminate leadership thinking through a national committee of experts on questions of the appropriate design for class settings, the selection and maintenance of teacher personnel and the use of ancillary clinical services to reinforce the primary educational function.

- (3) To define what is meant by special education and to develop educational provision and methods especially adapted to the potentials, limits, needs, and pace of mentally ill children.

- (4) To develop and organize special training curriculum beginning with the undergraduate level and continuing through master's and doctoral programs that include special academic training and supervised fieldwork in approved diagnostic, educational, and therapeutic settings for mentally ill children.

To facilitate the above special education program, we further recommend:

(1) That a national body or organization (public or voluntary) be delegated with the responsibility of developing standards, training, special education theory and practice in work with mentally ill children.

(2) That this national body, or organization, appoint a national committee or committees of experts from special education, psychiatry, psychology and social work to collect information on current thinking, experience and problems of those responsible for training programs and of those educators and clinical personnel directly working in special settings for mentally ill children, and to develop leadership and direction in all previously enumerated critical areas of special education for national distribution.

Let us now assume that the emotionally disturbed child with whom we have been concerned has completed his course of special education under the tutelage of specially trained teachers and is ready to choose a vocation. What now? Even the emotionally handicapped child can learn to follow a routine and studies should be made to determine those occupations he can enter which will use his abilities and allow him to function in an environment which does not offer too many pressures. This kind of occupational training and research for adolescents should be conducted at both inpatient and outpatient levels.

You have invited us to suggest how you can help us in the field of vocational rehabilitation. Here then are our recommendations for your consideration in this area:

Federal and State Governments should work cooperatively toward—

(1) raising of standards in care, treatment and education of mentally ill children in State hospitals—with special attention to the needs of mentally ill adolescents for vocational guidance and training.

(2) provision of halfway houses for children ready for discharge from inpatient facilities.

(3) provision for additional supporting services to child and family to protect previous therapeutic investments and maximize the child's ability to assume a limited though productive role in society. These must include sheltered workshops, protected employment, social and psychological services for child and family to support and enable the child or young adult to take and maintain his place in community living.

(Further details concerning the need for special vocational rehabilitation for these teenagers are included in this report, which I will not take the time to read but am attaching for your further study.)

If we are to develop a new attitude of hope for these children, it cannot be done by propaganda alone. The community will change its attitude only when we demonstrate that something can be done for these children, and this can be shown only in the actual doing. We must act before another generation of troubled children become the mentally ill adults of the future.

Mr. DANIELS. Thank you, Mrs. Carson.

Are there any questions?

Mr. QUIE. I have one question. Since you are the president of the National Organization for Mentally Ill, you say in Pennsylvania the mentally ill are not included in the definition of the handicapped child.

How many States are there not included in the definition of the handicapped child, similar to Pennsylvania?

Mrs. CARSON. Many States. I know that New Jersey and New York just received a bill of special education for these children.

You see, we do have an existing school code for special education which includes physically and mentally handicapped, but the interpretation has been that mentally handicapped is only in regard to mentally retarded and does not include emotionally or mentally ill children.

This has been our problem in Pennsylvania.

Mr. DANIELS. You do not know exactly how many States there are?

Mrs. CARSON. I don't think there are many States that do have these children included. I think it was 1949 and then in 1954 the bill was revised and amended which then included the mentally handicapped child.

So I am not too aware of the existence of bills in other States.

As I pointed out they are nothing more than public policy at this point. They are not mandatory bills. In New Jersey I know and I am not sure whether the one in New York is mandatory, or not.

Mr. QUIN. You do not have a mandatory bill in Pennsylvania for the education of any handicapped child?

Mrs. CARSON. Yes, we do for physically and mentally—my point in the report being this, they did not interpret mentally handicapped which you have done so well in this report, and the thing that makes us feel quite good, that you have spelled out mentally ill rather than—as a matter of fact, the thing that we are intending to do now is to get a reinterpretation from the attorney general because we, of course, are assuming that the mentally handicapped should obviously include mentally ill children as well.

There was an amendment 1339 which just failed which definitely spelled out mentally ill children. It was defeated very recently.

We are very unhappy about that situation at this point.

Mr. DANIELS. Thank you, Mrs. Carson.

Mrs. CARSON. Thank you.

Mr. DANIELS. Our next witness is Mr. Roger Davis, executive director, the Goodwill Industries of Philadelphia.

STATEMENT OF ROGER DAVIS, EXECUTIVE DIRECTOR, GOODWILL INDUSTRIES, PHILADELPHIA, PA.

Mr. DAVIS. Thank you.

Mr. DANIELS. Mr. Davis, you will be limited, as usual, as all the other witnesses have who appeared, to 10 minutes in the rendering of your testimony here.

If you have a written statement, you may file that with the reporter.

Mr. DAVIS. I do have a written statement, Mr. Chairman. I would like to merely make one or two observations and let the statement itself suffice.

Mr. DANIELS. All right, sir, your written statement will follow your oral testimony in the record, without objection.

You may proceed.

Mr. DAVIS. We are, of course, in Goodwill, very much interested in the parts of the legislation that deals with the expansion of sheltered workshops through Government grants.

But one observation which I would like to draw is that during the past 10 or 15 years many thousands of handicapped people have annually passed into the labor market without having to come through sheltered workshops or special facilities.

What we feel is that in the age of automation which is now well underway, many of the people that have passed into industry, handicapped people, may well be coming back out of industry as a result of automation and perhaps be thrown on to sheltered workshops or need the facilities for retraining.

Consequently, this adds in my thinking, new significance to legislation that would aid in expanding sheltered workshop facilities.

While this is only an assumption on my part—actually the automation has not gone too far, we do not in the next 5 to 10 years in factories and offices—many of the handicapped people employed there are marginal—they will be the first to be released.

Consequently, a new challenge, perhaps a greater challenge than we anticipate now will be thrown to the sheltered workshops.

I would like to thank the committee for its study in this field of legislation. I feel that whatever comes out of it will be most helpful in helping us to see the total job that has to be done.

Thank you.

Mr. DANIELS. Mr. Robert F. Irwin, board member of the National Society for the Prevention of Blindness.

(The statement of Mr. Davis follows:)

STATEMENT OF ROGER DAVIS, EXECUTIVE DIRECTOR, GOODWILL INDUSTRIES OF PHILADELPHIA AND VICINITY, INC.

May I first take the opportunity to express, on behalf of the board of directors of Goodwill Industries of Philadelphia and Vicinity, Inc., and myself, our sincere appreciation to the subcommittee for the study it is making in the area of special education and rehabilitation.

As Benjamin Franklin once said, "It is easy to see, hard to foresee." Certainly the work of this committee and the report that it will bring forth cannot but help all of us in the field of rehabilitation to foresee the magnitude of the challenge that lies ahead of us.

In seeing the problem of providing adequate workshop facilities for the handicapped in Philadelphia and vicinity, we would appreciate the subcommittee's consideration of the following:

1. For the Philadelphia Goodwill Industries to meet the minimum needs of the type of handicapped people it serves, in its sheltered workshop facilities, we should establish at least four wholly integrated workshops in the Philadelphia metropolitan area. We currently have two workshops serving an annual total of 550 handicapped men and women. There are an additional 600 handicapped people on our waiting list.

2. To meet the needs of handicapped people in the area outside of the Philadelphia metropolitan area, Goodwill Industries should establish two additional workshops in Reading, Pa., and Allentown, Pa. In these two areas, Goodwill Industries could be serving 250 to 300 annually.

3. As a member of Goodwill Industries of America, Philadelphia Goodwill along with 120 other Goodwill Industries throughout the United States comprises the world's largest voluntary nonprofit sheltered workshop association. In the past 10 years, Goodwill Industries has more than doubled the number of handicapped people that it serves annually. As such, it is my firm conviction that the voluntary agency approach in cooperation with State and Federal agencies has proven its ability to undertake the challenge of meeting the needs of handicapped people in the sheltered workshop area.

In its approach to serving handicapped people, Goodwill Industries does not attempt to center its program on the needs of just one or two areas of disability—rather ours is one that covers the broad scope of disability with no restriction as to maximum age limit.

4. To provide the necessary facilities for adequate workshops, I feel the following must be accomplished by local, State, and Federal groups:

(a) Funds for new building construction.

(b) Funds for renovation and expansion of present facilities.

(c) Funds for modern training equipment.

(d) Funds for adequate professional staffing of present and contemplated additional facilities.

Mr. DANIELS. The next witness will be the Reverend Francis LeBlanco, director, Apostolate for Mentally Retarded.

**STATEMENT OF REV. FRANCIS LeBLANCO, DIRECTOR,
APOSTOLATE FOR MENTALLY RETARDED**

Father LeBLANCO. I would like to thank this committee for the invitation to testify to the needs of special education in this area.

I feel that I have some small competency to discuss these needs with you, for during the past 5 years I have been working with retarded children and their parents.

In my position as director of special education, both with the Mount Carmel Guild and the Archdiocese of Newark, I have personally arranged service in areas of religious instruction, social and recreational activities, as well as workshop, and psychological evaluation, for over 500 children of various ages and degrees of retardation.

From this experience certain needs manifest themselves:

1. Nursery and preschool facilities: In this State as in many others, there is an incredible lack of adequately staffed and trained institutions for low grade retardates or for unwanted and neglected educables on the nursery and preschool level.

If some Federal funds were allocated to the States budgets, and scholarship grants made more accessible, some headway might be made in overcoming this tragic lag in our resources.

If some Federal funds were allocated to the parent associations for retarded children and to other private nonprofit organizations to help establish accredited facilities, a great contribution to the welfare of these children would result, as well as the alleviation of great emotional and social problems for the siblings and parents.

2. Evaluation and diagnostic clinics: Since early diagnosis is paramount to proper planning for the retardate, more funds allocated to the clinics serving specifically the needs of the retarded, and for counseling of parents, would assure future success in adjustment for both.

3. The retarded blind: At present there are few, if any, institutions to cope with this multiple handicap, with the result that many, if not all, are receiving no educational experience. Some consideration must be given these unfortunates and their needs.

4. The other retardates: Here we have a population of retardates, who are 16 years of age and over who for some reason or other have not seen fit to continue in existing school systems, or who have been excluded for lack of academic ability.

The parents of these retardates are concerned for their eventual futures. Some of these are fortunate enough to fit into existing training programs sponsored jointly by the State, rehabilitation commission, and private agencies, but these facilities are all too few because of the financial restrictions placed upon such programs.

Some consideration in terms of financial security should be given these agencies.

As it stands, many groups are frightened away from these training programs and workshops because of the chronic fear of insolvency.

At this point I would like to make a public statement of appreciation to the Office of Vocational Rehabilitation, especially to Mr. Salvatore DeMichael, to the New Jersey Rehabilitation Commission, which under the capable and dynamic leadership of its former director, Lawrence Houston, and its present directress, Mrs. Carl Holderman, who

have been responsible for most, if not all, of the training and sheltered workshop programs in New Jersey.

A special word of thanks to Mr. William Seligman and Miss Gertrude Neary, who have spent many efforts to guarantee a service of excellence to the retardate.

Most, if not all, of the progress in this area is due to the New Jersey Rehabilitation Commission, and it is with sincere joy in my heart that I endorse the enactment of H.R. 3465, which will allow even more development under such leadership.

One word of caution concerning this legislation: It will be as effective as resources of the commission which directs it, and some definite financial consideration should be given to the recruiting of counselors and other key workers on the State level.

At present our rehabilitation staffs are overworked, with amplification of services to the less feasible, they will be smothered, and the aim of the total program will be frustrated.

I would also at this point ask consideration of the need to lower the age of eligibility for rehabilitation services to 14, this would enable a cooperative joint action between the rehabilitation and the school system, to the eventual benefit of the handicapped client.

The rehabilitation commission with its wealth of employment training experience would thus be available to the school systems, and they, in turn, would cooperate in early discovery of candidates for rehabilitation services and in planning of curriculums to meet the needs of future vocational training for them.

Once again I wish to thank the committee for its invitation, as I feel that by participating in its work I am sharing in the fulfillment of a great dream, one in which all of God's children will benefit.

May Almighty God bless you and your work.

Mr. DANIELS. We appreciate your coming here, Father LeBlanco, and giving us your views.

Our next witness is Mrs. Armond Johnson, chairman, Legislative Committee, New Jersey Association for Mental Health, Montclair, N.J.

In the absence of response, I shall call Miss Lucy G. Morse, president, Maryland Occupational Therapy Association, Baltimore, Md.

STATEMENT OF PERCY CLARK, NEW JERSEY STATE HOSPITAL, MARLBORO, N.J.

Mr. CLARK. Mrs. Morse has not been able to be here. She has authorized me to present her findings, if this is in order.

Mr. DANIELS. Without objection, the statement of Mrs. Morse will be filed in the record.

Mr. CLARK. I won't take the time to go through her report, because she has it prepared only to point up maybe two or three things she has emphasized.

She again emphasized the need for personnel and something she calls grants-in-aid to take care of this and to take care of recruitment and publicity.

Mr. DANIELS. Sir, if you will file the statement with the reporter, the committee will give it its careful study and consideration.

Mr. CLARK. Thank you.

(The report referred to follows:)

STATEMENT OF LUCY G. MORSE, OTR, PRESIDENT, MARYLAND OCCUPATIONAL
THERAPY ASSOCIATION

Mr. Chairman and members of the committee, I am appearing here today as a representative of the Maryland Occupational Therapy Association to speak in favor of the proposed bill, House Joint Resolution 494, to provide for training of teachers of the deaf and for training speech pathologists and audiologists. I would like to speak also of the needs of the occupational therapy profession in my State.

PERSONNEL

There is a great need to increase the number of trained occupational therapy personnel to help make available vital services to those children and adults in our country who are in need of physical and mental rehabilitation. Today there are only 6,106 registered occupational therapists to meet this need. Compare this to the 14,000 military and civilian job opportunities currently available to occupational therapists. By 1962 the projected need is estimated at more than 15,000.

This is reflected in Maryland, for example, by the serious situation in the department of mental hygiene, where more than 15 positions have been unfilled by registered therapists for 4 years. Two of the larger hospitals in the Baltimore area, with a total bed capacity of more than 1,000, have been without trained leadership in occupational therapy due to the lack of trained personnel. There are currently five other hospitals in Maryland where there are no occupational therapists employed. The Maryland Occupational Therapy Association now has members from 21 institutions and agencies in all parts of the State. It is estimated that the organizations these therapists represent will need 30 to 50 additional therapists by 1962.

GRANTS-IN-AID

In order to facilitate the training of additional occupational therapists, it is urged that a program of grants-in-aid be developed to assist public and nonprofit institutions to assist such schools in the provision of this training. This grant-in-aid program should include provision for recruitment and publicity. The State of Maryland has no academic training program for occupational therapists. One institution carries a clinical training program in affiliation with several schools in other States—Pennsylvania, Virginia, New York, etc. Students in Maryland who wish to consider this profession are often discouraged because of the expense of going out of the State for their education. Scholarship grants are needed covering all undergraduate training. To quote a member of the department of mental hygiene, "scholarships seem to be readily available for some professions but are limited or not available for occupational therapists."

RECRUITMENT

The Maryland Occupational Therapy Association has attempted to inform other professional associations of the primary importance of recruiting additional therapists. Lack of funds to do an adequate job has been a major difficulty. No institution has been in a position to pay for recruitment of students for a profession, especially if that training takes place outside the State. These institutions are fortunate if they can recruit qualified graduates for available positions. A grant for recruitment of occupational therapists in Maryland administered through an appropriate Federal agency or educational institution is definitely needed.

The Maryland Occupational Therapy Association would like to go on record as supporting House Joint Resolution 494. Occupational therapists do not work independently of others. Desired standards of care require good working relationships between the various professional groups included in the physical and mental rehabilitation of the handicapped. The professional personnel provided for in this bill are in very short supply. The passage of this bill will materially assist in filling a serious gap in services. While this represents a step in the right direction, rehabilitation requires a team approach. This dictates the need for adequate representation by all professions.

COOPERATION OF SERVICE AGENCIES

The provisions proposed in the independent living bill, H.R. 3465, also affect the occupational therapy profession. Occupational therapists work primarily in cooperation with health services, though in assisting clients to achieve rehabilitation goals they work closely with the division of vocational rehabilitation. Therapists in community work also cooperate with public welfare agencies. It is important that cooperation between agencies performing these services be strengthened.

EVALUATION

There is a need for all health and rehabilitation agencies to include a formal method of evaluation as a part of their total program. To be effective evaluation services must be available on a continued basis. The division of vocational rehabilitation in Maryland has established two adult evaluation clinics. The Heart Association of Maryland has a work evaluation unit. All are studying practical methods of evaluating disability, and for cardiac clients, of determining employability. Frequently, clients who are found to be not quite ready for competitive employment are referred to occupational therapy for work tolerance training in the home or to sheltered employment. In Maryland this kind of referral is only available in Baltimore City and two counties due to the lack of personnel, facilities, and funds.

DEMONSTRATION

Additional Federal funds will play a valuable role in creating new opportunities for demonstration projects that are vitally needed in the general field of independent living. An even greater need is for a pilot study of a whole population area to determine the total unmet needs of the handicapped. To our knowledge no such evaluation has been completed.

SHELTERED WORKSHOP

In Maryland, 30,000 disabled persons require rehabilitation services to achieve a satisfactory employment adjustment. In 1959 the division of vocational rehabilitation had contact with 8,257, or 27 percent of these citizens. Occupational therapists serve largely during acute and early convalescent stages of rehabilitation. The problems of the aging and the chronically ill require longer service. Many occupational therapy patients are not eligible for rehabilitation services under the present law. The cooperation of the division of vocational rehabilitation and the local sheltered workshops has been of great value in providing a continuing service. Unfortunately, these facilities and services do not satisfy total patient needs. The independent living bill will help to meet some of this need.

The average occupational therapy department is not equipped to simulate normal working situations for their patients. Sheltered workshops in Maryland have been unable to absorb those who need relatively short work tolerance or testing training due to lack of facilities and money. The Goodwill Industry of Baltimore needs to at least double their present work area. The lack of money to finance the training of a relatively nonproductive client in this stage of his rehabilitation is a typical reason given for not including a large enough program of this kind in Maryland sheltered workshops. There is need for a pilot study to determine community needs for sheltered workshop facilities. Physicians in charge of rehabilitation programs in Baltimore city hospitals, Montebello State Hospital, Johns Hopkins Hospital, and the Heart Association of Maryland all state there is a need for sheltered workshop employment of persons who need short-time testing or work tolerance experience.

The Maryland Division of Vocational Rehabilitation has 35 professional staff members and needs 100 just to adequately administer their current program. The independent living bill will add to this difficulty by adding new services such as homemaking. We believe this to be a needed service. However, if adequate provision is not made for trained professional personnel these additions in services will obviously represent no increase in total service. Another example of this is given on page 16 of the bill, lines 11 and 12. There is difficulty in securing occupational therapists for positions that are currently open. The problem of lack of trained personnel to provide rehabilitation services is a far greater problem than lack of facilities.

The Maryland Occupational Therapy Association endorses H.R. 3465 as a step forward toward meeting total patient needs for rehabilitation services.

Mr. DANIELS. Mrs. Eone Harger, chairman, New Jersey Commission on the Aging, Division of Aging, Trenton, N.J.

Mrs. Harger, all of the witnesses have been limited to a period of 10 minutes in their testimony. I note that you have a statement. Perhaps you might want to summarize your views, in which event your prepared statement will follow your oral testimony, or you may read from your statement, whichever you desire to do.

You may proceed.

STATEMENT OF MRS. EONE HARGER, CHAIRMAN, NEW JERSEY COMMISSION ON THE AGING, DIVISION OF AGING, TRENTON, N.J.

Mrs. HARGER. Thank you.

I am going to speak very briefly. I won't take the 10 minutes because I am endorsing what some of the other State agencies have testified to before you.

I am very happy to have an opportunity to come here and give this endorsement. I come from what is called the division of aging and we do not do any direct service. We are a coordinating and a research and community organizing agency.

What I would like to do is support the principles which you have put into H.R. 3465 and H.R. 119.

We studied them in our division and have based an evaluation of them on our accumulated knowledge of the needs and resources of the aging in New Jersey, plus our knowledge of the experience of the rehabilitation commission and the department of health and other agencies which deal with problems of older people.

We probably are already aware that here in New Jersey we have a great many aged people, that is, people over 65.

In 1950 it was nearly 400,000; in 1960, we know it is well over 500,000—a half million.

We generally accept that this aged group is subject to more illness than the other groups in the population and we do know they don't have the economic means to pay for the rehabilitation.

We feel that many of them could be rehabilitated to self-living, taking care of themselves if there were facilities available.

This has been demonstrated in a project in Essex County. If this could be extended to other parts of the State, we think in terms of human values and in terms of actual dollar value to the people of the State, it would be tremendously useful.

It is our conviction that the provisions which are contained in these bills which you are having hearings on today are a progressive step in the conservation of human resources.

Whenever members of society, whatever their age, are restored to maximum potential as functioning citizens, society will benefit.

We would like to see these principles put into operation.

Thank you.

Mr. DANIELS. Thank you, Mrs. Harger. Your written statement will follow your oral testimony.

Mrs. HARGER. Thank you.

(The formal statement of Mrs. Harger follows:)

TESTIMONY PRESENTED BY MRS. EONE HARGER, DIRECTOR OF THE NEW JERSEY
STATE DIVISION OF AGING

I wish to thank the committee for inviting me to attend these hearings and submit testimony, which will be very brief.

The division of aging is a coordinating, research, and community organization agency; it does not provide direct services to older people.

We firmly support the principles of H.R. 3465 and H.R. 119, which we have studied thoroughly: Our evaluation is based on our accumulated knowledge of the needs and resources of the aging in New Jersey plus our knowledge of the experience of the rehabilitation commission, department of health, and other State agencies within this area of concern.

In 1950, there were 393,989 people over 65 in this State—in 1960 it is estimated that there will be 508,660. It is generally accepted that this age group is subject to debilitating illness. It is also generally accepted that the average person over 65 does not have the economic reserves to pay for adequate restorative service.

It is our conviction that the provisions contained in the bills in question represent a progressive step in the conservation of human resources. When the members of a society, whatever their age, are restored to their maximum potential as functioning citizens, society inevitably benefits.

Mr. DANIELS. Is Mrs. Jane Davis Ellen here?

I notice you have been sitting here all morning. You have heard my admonition to the other witnesses, so I will not repeat it.

STATEMENT OF MRS. JANE DAVIS ELLEN, EXECUTIVE DIRECTOR,
MARYLAND SOCIETY FOR THE PREVENTION OF BLINDNESS,
BALTIMORE, MD.

Mrs. ELLEN. I don't have very much to say. I will try to make it brief.

My presence here is as a representative of, primarily, the Maryland Society for the Prevention of Blindness, our parents' committee for the children with partial sight, and the informal thinking of the teachers of partially sighted children in the public school system of the State of Maryland.

I would like to say that our concerns are primarily confined to those of children with visual handicaps who are not presently eligible for the educational material and services provided for those who fall within the definition of legal blindness.

In considering unmet needs of visually handicapped children, it was the consensus of our group thinking that the greatest basic single need was a redefinition of the terminology which is now employed to describe the visually handicapped particularly if there was to be any intelligent consideration or discussion of unmet educational rehabilitation needs.

Such definition would distinguish the truly blind, those without useful light perception from the partially sighted.

The partially sighted would then need to be classified on the basis of the type and the degree of sight loss as well as the functional capacity and functional disabilities of the individual. In this way the needs of visually handicapped individuals could be met each according to his particular requirement.

Our recommendation, therefore, would be that there be some appropriate means provided at the national level to arrive at a functional definition of visual disability. This is not intended or implied to mean that any present services be curtailed or discontinued. It is intended to expand the existing provisions to include primarily at this point children who are visually handicapped, but not legally blind.

It was the feeling of the group that in considering special education and rehabilitation of these children that there are needed more valid means of measuring intelligence and achievement. This would, therefore, seem to suggest that research is needed in the field of the development of appropriate testing material in which the visual disability would not mask the test result.

In line with our other basic recommendation of a redefinition of the visually handicapped, we would hope that there would be further development, production, and distribution of a variety of educational material, records, tape recordings, large type books, and other equipment.

That these materials be provided again on the basis of the individual need, not on the definition of legal blindness.

Our recommendation would include, of course, increased Federal funds for the production of such material. It was felt in the relationship of special education for vocational rehabilitation that the answer to this problem will probably have to be met in light of local existing services and facilities, but that vocational rehabilitation should be legally permitted to make its services available to special education of the visually handicapped as may be needed in the solution of individual case problems.

At the present time there is a consulting guidance relationship, but in individual instances there needs to be available a more direct kind of service.

The other great unmet need we felt for the visually handicapped was an orientation or counseling service for parents of preschool-age, visually handicapped children. I think we would even place this ahead of actual preschool education of these children simply because it is in the formation of attitudes toward the physical disability that to a large extent determines the ability of the child to take advantage of the opportunities then provided.

I would like to say that we have not formulated a statement in relation to the special education of the multiple handicapped child, those with visual disabilities as well as others, and feel that in the light of other things that have been said here this morning there is great need for provision of educational services for children with a combination such as frequently happens with cerebral palsy, vision, mental retardation, and so on.

Thank you.

Mr. DANIELS. Thank you.

Are there any questions?

Mrs. ELLEN. Thank you for the opportunity.

Mr. DANIELS. I would like to call at this time Mrs. John Cummings, of Jersey City.

STATEMENT OF MRS. JOHN CUMMINGS, JERSEY CITY, N.J.

Mrs. CUMMINGS. My name is Gertrude Cummings.

Mr. DANIELS. Mrs. Cummings, I would like to say before you start your testimony that we must limit each witness who appears to not more than 10 minutes in this testimony.

Mrs. CUMMINGS. All right. I am not prepared and I am not a public speaker, so you will have to put up with any kind of mistakes I make.

I speak on behalf of my son who is 16 years old. At present he is doing nothing. He is sitting at home. I have gone through every kind of means to try to get some help for him.

Right now he is capable of doing third and fourth grade work. There is nothing physically wrong with him. He is a good, healthy child. He right now should be learning a trade. He cannot fit into any of the regular schools here in Jersey City because he can only do third and fourth grade work but does not belong in the regular grammar school because he is too old.

He has attended parochial and public schools here in Jersey City. He just kept getting left back because they do not have time to put up with a child like that.

I have had to take him out and—at very great expense to me which ran into thousands of dollars—my son had to attend a private school, just part time in New York. This man let my son come there at a great discount because I could not afford it. Even so, it has drained us of all our funds.

In the meantime my son traveled there. I had to go with him at first. Later, he traveled by himself. Right now I know that he is not going to be a scholar, but my son should be getting some sort of training.

I think there are many other children like him. This you can see right from the beginning when a child is in the first, second, or third grade. These things are noticeable. They told me about it, but they could not do anything about it. Nobody could instruct me where to go or what I could do.

I think a child like that should be started in a trade right at the beginning. Years ago they used to have apprentices. In this way they learned something. He is capable of doing some work. I have also inquired about a trade school and I know a very good one, but he would have to be at the high school level.

Right now that is my problem. Something should really be done with these children. Not just a lot of talk because I get that all over. Something definite. I think this Government really should do something for these children. He is an individual like anybody else and he is entitled to some training.

Mr. DANIELS. For the purpose of the record, will you give us your home address?

Mrs. CUMMINGS. My address is 257-A Fifth Avenue.

Mr. DANIELS. Have you always resided in Jersey City, Mrs. Cummings?

Mrs. CUMMINGS. Yes.

Mr. DANIELS. Your son was a student of the Jersey school system?

Mrs. CUMMINGS. Yes.

Mr. DANIELS. What, in your opinion, is the nature of the handicap that your son is suffering from?

Mrs. CUMMINGS. They considered it an emotional disturbance, a slight emotional disturbance. He is one of these children who can't seem to take to schoolwork. He is absolutely no behavior problem. He has nothing physically wrong with him.

Mr. DANIELS. When did this condition first make its appearance?

Mrs. CUMMINGS. He was left back in the first grade, and then it continued. That was the first time I had seen it. I thought he would need some more time, but later on I could see he needed some special training.

They wanted to put him in a special class and from what I understand a special class in Jersey City is a mixed group and he would sit there. I don't want that. I want to bring out the best I possibly can. I want to teach him a trade. I don't have anybody that is a plumber or carpenter that could take this child and help him get along.

Mr. DANIELS. You see, this committee is making a study in the field of special education and rehabilitation. We know that there are many, many shortcomings in the school system, not only in Jersey City, the State of New Jersey, but also in the other 49 States of this country.

We thought that, because of those shortcomings and the problems that arise, something should be done about it. That is the objective of this committee: We would like to know what those shortcomings are, what the role of a Federal Government is in these various areas, and what we can do to assist the States and the local communities in developing a program for the assistance of boys and girls and the children similar to your child.

Just exactly what will be done, we are not in a position to say, because this is the fourth regional hearing that this committee has conducted and we have other hearings to conduct in other parts of the country. Upon the conclusion of this study we will make recommendations to Congress.

Mrs. CUMMINGS. Yes, I hope you really will.

Another thing, you may not be able to help my son because he is quite old, but there are many boys like him. If you would care to investigate you can see they are pushed from one grade to another because they are too old to stay in their classes.

Mr. DANIELS. Mrs. Cummings, we have been listening to testimony for the past day and a half. We have done so in the State of New York for 2 days, in New Haven, Conn., and in Cullman, Ala. Next month we are going out West to study the problems.

I want to tell you that, more or less, these problems exist in each and every area. They may differ in degree, but the problems do exist almost everywhere.

We are looking forward to proposing legislation to Congress and hope that our colleagues in the Congress will accept our views.

Mrs. CUMMINGS. Yes, Dr. Earl Taylor, from New York, who has run the school, has had great experience in treating children like that, also. That is where my son has had his training.

Mr. DANIELS. I am very pleased and happy that you came here. I want to congratulate you for coming forward and speaking so frankly about your problem. You are to be commended in coming here to express your views.

Mr. QUIE. What kind of training did your boy receive in the New York school?

Mrs. CUMMINGS. First of all, they have some sort of machine—I don't remember the name, it is a technical name—where he had to first exercise the muscles in his eyes. After that he had special training, he had a private teacher.

Whatever he needed they went along with him at first. Because of all of this he had become very frustrated and upset and emotionally disturbed because of this pushing around from one school to another.

We wanted to bring out the best in him. They tried to work with him right with his problem from the beginning. They gave him the regular academics only.

Mr. QUIE. There is no vocational training?

Mrs. CUMMINGS. No, that is why he had to leave. I know he grasped as much as he was going to. Also, because of his age, I thought it was time for him to start on a trade.

Mr. GIAIMO. When did your son first receive diagnostic investigation?

Mrs. CUMMINGS. I think it must have been around eight or so. That was done at the Stevens Institute. I took him there at my own expense. The most that they had told him was that it was a great anxiety and emotional disturbance.

Mr. GIAIMO. That was done only because you suspected there was something wrong?

Mrs. CUMMINGS. That is right.

Mr. GIAIMO. There was nothing done before that in the school system?

Mrs. CUMMINGS. Absolutely nothing outside of maybe the regular IQ test that they give them. All they did was give me words of sympathy. Not one teacher in either the public and parochial schools could even advise me to go anyplace.

I had heard of this school through a man I had started to study with to be a beautician. This man had sent his daughter there because she also had some sort of reading problem or something. He told me about the school. I took my son there.

Mr. GIAIMO. Thank you.

Mr. DANIELS. Thank you, Mrs. Cummings.

Mrs. CUMMINGS. Thank you again.

Mr. DANIELS. Now I turn the chair back to our chairman, Mr. Elliott.

Mr. ELLIOTT. Thank you very much.

Now the next thing that I desire to do is to present the statement of U.S. Senator Harrison A. Williams, of the State of New Jersey, which written statement in connection with this matter has just arrived.

Without objection, this statement will be made a part of the record at this point.

(The statement referred to follows:)

STATEMENT OF HON. HARRISON A. WILLIAMS, A SENATOR FROM THE STATE OF NEW JERSEY

Thank you very much for offering me the opportunity to present my views to your committee on the unmet needs in special education and rehabilitation and the role which the Federal Government can take in assisting local communities to find a solution to some of the most urgent problems in these fields. The committee is to be commended for taking the time and effort to make this much-needed study. The committee's program of holding regional public hearings in order to better assess the adequacy of existing services and the particular needs of special education and rehabilitation throughout the country is particularly worth while, since the need for more information and better understanding of the problems in this area is very great.

It is my desire to address myself this morning particularly to H.R. 3465, a measure introduced by the Honorable Carl Elliott, chairman of this subcommittee. As I am sure the members of the committee know, S. 772 has been introduced by my esteemed colleague, Senator Lister Hill of Alabama, and is presently before the Senate Committee on Labor and Public Welfare, of which I am a member. This bill is similar to H.R. 3465 and is intended to achieve the same purposes.

At the time our National Legislature amended the Social Security Act to provide for cash benefits for the totally disabled over 50 years of age, it was also provided that the rehabilitation services of the various States would review applications for such benefits before they were granted. Since this program has been put into practice, a great deal of information with respect to the disabled has been developed. Persons working in this field have discovered that there are a tremendous number of disabled persons who are not presently eligible for the benefits available in our various Vocational Rehabilitation Services because of the proviso in the law governing the Vocational Rehabilitation Service which requires that the applicant for rehabilitation be employable after a program of rehabilitation. Many of these people are patients in nursing homes, in our public and private hospitals or are receiving attendant care at home. In short, these people are unable to care for themselves and are presently public or private charges. They occupy bed space in our sorely overcrowded hospitals, although in view of the other needs of the community which the hospitals must serve, there is no proper basis for their hospital stay. Whether the nursing homes be publicly or privately supported or these unfortunate people be patients in their own homes or the homes of relatives, the cost of their care is being borne in many instances by the community at large. In those instances where private funds are supporting the care of these unfortunate individuals, it is almost a truism that sooner or later they will become public charges. These individuals have lost the independence that they might have, have lost the opportunity to lead the active lives that they might lead, have become a greater burden on their families or society than is necessary and constitute a social cost to society as to all the idle. There is no end in sight to the need for their care because there is no organized program for their rehabilitation. This legislation would make a good start in this worthwhile effort.

The provisions of this legislation would provide grants for independent living, rehabilitation services for persons requiring institutional care or attendance in their household, to enable these persons to achieve a measure of independent living sufficient that they will no longer require such institutional care or attendance, and be of great help in meeting the problem which I have previously described. I believe that it would not be incorrect to say that a successful program of this nature will actually reduce the public's present welfare cost by more than the amount of money expended in this effort. It should also materially reduce the cost to the public of providing for additional hospital beds for the care of these individuals. Certainly it will make more hospital beds available for other types of more urgent medical and surgical use.

The legislation would also provide funds for evaluating the nature and extent of the disabilities and rehabilitation potentials of handicapped individuals. Too often there is a breakdown in the rehabilitation of the individual because of a lack of a comprehensive diagnosis of the disabilities of the individual and a particular program for rehabilitation predicated upon adequate knowledge of the disabilities. With the funds and program available under this legislation, if enacted into law, much can be done to cure this difficulty.

Here in New Jersey we are aware of the urgent need to establish more workshops and rehabilitation facilities as aids in the rehabilitation of the handicapped and to furnish employment opportunities for the handicapped who are confined to their homes. We desperately need more facilities to provide pre-vocational therapy, vocational training, and other types of occupational therapy and training. We are also in need of expanding this sort of service within the framework of an integrated program under the aegis of competent professional supervision. I am, therefore, particularly anxious to support title III of H.R. 3465 which provides funds to meet this need. In our State much has been done by our State government and by interested volunteer workers, but we have only scratched the surface when one considers all that might be done in this field.

Even as this committee meets, our Nation is locked in a struggle for survival as a free nation and as the leader of free nations throughout the world. Among our handicapped citizens are many, many people who would, if they could but get the proper training and opportunity, make a substantial contribution to the economic strength of our country. This legislation would not only make this positive contribution possible, but it would also help to eliminate the economic drain of relief and other welfare programs which help to support many of our handicapped but do not enable them to become useful members of our society.

In view of the great need for the entire program contained in this legislation and in view of the positive benefits which all of our citizens will obtain if the program embodied in this legislation is put into effect, it is a privilege to testify before your committee in its support.

Mr. ELLIOTT. Now, is Mr. Albert I. Oliver here?
What is your field, Mr. Oliver.

**STATEMENT OF ALBERT I. OLIVER, ASSOCIATE PROFESSOR,
UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PA.**

Mr. OLIVER. My main work is known as curriculum development in teacher education.

Mr. ELLIOTT. You may proceed.

Mr. OLIVER. I have here a statement which I will present for the record. I don't know whether you care to have me read it, or rather have me make a few summary remarks.

Mr. ELLIOTT. You may proceed for 10 minutes, Doctor. You do it whichever way you think is best.

If you decide to summarize it, then the full statement will be made a part of the record following your oral remarks.

Mr. OLIVER. All right.

I am here representing the group known as the gifted. In special education there are two terms which we sometimes associate. One is that of the handicapped and I suppose you could make a case for the point that being a person with brains might be a handicap under some conditions.

We know that many youngsters in schools sometimes have difficulty with their own group because they don't want to be known as brains.

We also recognize that people with physical handicaps and other kinds of handicaps may have high mental ability and as such are classified in that category.

Actually, in the bulk of the people with whom we are concerned I think the word exceptional is the word that we are concerned with.

This is a relatively small group perhaps, but we feel that particularly in terms of the great needs for both manpower and mindpower here in the United States that this group is one that is greatly neglected in our school.

For example, fewer than half of the upper 25 percent of our high school students ever enter college and finish getting college degrees.

We know in many cases that people have high ability, but do not operate at that level and are known as unachievers.

There are, depending on how you define this, from a million and a half to 2 million gifted children in the United States.

Mr. ELLIOTT. How do you define the gifted, Doctor?

Mr. OLIVER. I would, first of all, tie this word in with mental superiority because sometimes the word gifted means a person who can play a piano or something like that. This is a kind of gift—

Mr. ELLIOTT. Is that what you call a real gift?

Mr. OLIVER. I think, however, if you found a person who was a top performer in the musical field, he also would have high mental ability to go along with it. So there is a rather high positive correlation of these attributes.

But educationally speaking, we are concerned with those people who are probably in the upper, roughly, 5 percent of our population.

Mr. ELLIOTT. How do you correlate that term of the gifted, the upper 5 percent, with what we commonly refer to as general use?

Mr. OLIVER. When you get into the general use category you probably have less than 1 percent. A general use would be 1 out of 10,000—160 IQ if you want to use that index. Whereas, the group I am talking about would be roughly 125 IQ or better, although we would want to indicate that in identifying these people, which is one of our basic problems, that the IQ is not in itself sufficient.

There are other factors that need to be considered.

Mr. ELLIOTT. In determining the gifted?

Mr. OLIVER. That is right.

Mr. ELLIOTT. What are some of those other factors, Doctor?

Mr. OLIVER. The IQ of course, is simply determined by a particular test which is to some extent culturally determined. We have, for example, many youngsters—and they might be called handicapped in a cultural way—who have great ability, but because of the paucity of their environment, have not been able to produce effectively in our schools which are very much geared to verbal earning.

We also have, as I indicated, many youngsters who because of boredom—and I think this is one of our problems of the usual school program—or because of the fear of being labeled a brain, do not operate at their optimum level.

In one particular area, I am concerned about creative or originality.

Mr. ELLIOTT. I want you to expand on that a little bit, Doctor.

Mr. OLIVER. This is the kind of person who can go beyond the obvious, first of all. He is the kind of person who will see new relationships between facts, between ideas.

We have had for the past several summers at the University of Utah a series of workshops on creativity. They have identified about 28 characteristics of creativity as it is used on the job.

One of their comments, and this is why I was bringing this point in, is that, first of all, in the usual school test you have to go down about item 20 before you find a characteristic that is in their list of 28 in the area of creativity.

Secondly, they feel that the usual school program does not particularly foster creativity in addition to failing to identify it.

That is why I say I would look for these qualities of operation.

Mr. ELLIOTT. Do not these qualities of creativity sort of assert themselves in spite of the school? I see a gentleman shaking his head back there, but I disagree with him. I think they do.

Mr. OLIVER. We have many cases where they do. I gave two or three reasons why a youngster in his own personal relationship to the school will not produce. One of our serious problems is that of the so-called underachiever, who perhaps should operate at the upper 10 percent, but is operating maybe down actually the upper third.

Mr. ELLIOTT. Is that not because of the fact that he has not found the motivation of his life yet? Do not those fellows frequently find that motivation at maybe 20 years, or 30 years, even, and then those of us who are less fortunate have to get out of their way, so to speak?

Mr. OLIVER. This would be true in individual cases. In general, when you study the people you find that in the ones who are highly productive in ideas and other areas this comes fairly early in life.

You mentioned general use, which, of course, is a little bit of a category, but most of the people who are most productive do that and as a result of stimulation from the school or from individuals, but if they get bored with the school or if a youngster has to plod through, let us say, in science, some simple experiments in chemistry when at home he has his own chemistry set, he is way ahead of that, or in English class he read the book 5 years ago, it does not take very long for him to get discouraged.

We have evidence, in fact, yesterday we received this, 50,000 potential college graduates quit high school each year. This is not necessarily the gifted category in and of itself, but the potential.

Mr. ELLIOTT. How are we going to awaken that motivation in these youngsters, and that goes for the bright and those less bright, too? That, it seems to me, is one of the real problems of this age and perhaps every other age.

Now, there is a tendency in modern writing in this field to completely overlook the value of self-discipline. Yet those of us who have had experience in trying to put together an army of civilians, who have had practically no discipline, find that discipline is absolutely necessary and that once this army is disciplined it goes out and gives a fine account of itself in accomplishing its objective.

I do not know how we work in the concept of discipline into this development of creativity and motivation.

I do not know that is done, but it seems to me that this is the real problem and that the lack of discipline may have something to do with this terrible boredom that you and I are familiar with, where our children do not achieve as much as we would like them to achieve.

Mr. OLIVER. I should like to make two comments on that:

First of all, I think that we recognize the problem, but one of the reasons I am appearing here and one of the proposals I am making here, which I do not need to go over, is that there is very little co-ordinated study or research on this problem.

We need this kind of thing. We have very little research on the gifted as such. There have been things that have been tried, but not studied carefully.

The second thing is that when you are talking about discipline and organization, this creates a dilemma for a school person because a highly intellectual person tends to be a nonconformist.

When we try to mold him into the usual pattern of teaching and thinking and our curriculum, then he is either frustrated or becomes bored, or goes along to avoid any conflict, but does not develop this plus value that you and I are concerned about.

One of the problems that we have in our teacher education is to get both teachers and administrators aware of the fact that you have to handle these people differently, that you must be able to know where conformity of the usual type in education will stop and the nonconformity of the frontier thinking, the frontier action, will take off.

This, again, is an area in which we need both research and we need leadership and we need a considerable amount of inservice training, which is another one of my points.

MR. ELLIOTT. I do not want you to misunderstand me because I agree with the accomplishments of our civilization. Most of us are well housed and most of us obviously eat well, dress well, and have a few of the things that bring "good living," as we define it.

I am all for that, yet it seems to me that the great field of the motivation for the development of creative talents—certainly in an age gone by—grew out of necessity.

Maybe we do not have as much necessity in our daily living to bring about the invention, to paraphrase one of our old proverbs. Maybe the lack of necessity of this age is keeping some of our geniuses smothered.

I do not know. I have enjoyed ideas that you bring us. I realize as time goes on that we have to meet, head on, and wrestle with this problem that you are pioneering in right now. We are merely scratching the surface now. We must recognize it, must legislate and do other things necessary to take the enormous advantage of the genius and the gifts or our people.

I agree with that 100 percent. I recognize the gentleman from Connecticut.

MR. GIAIMO. Mr. Oliver, as a member of this subcommittee, I have always been interested in the problems of these gifted people. But I wish you would explain this to me: I can see the need in many areas for Federal assistance and Federal intervention in the field of handicapped, but I am not quite convinced I can see why the gifted should be a Federal problem.

Will you give me your thoughts on that.

It seems to me that if there is a breakdown, that it is a breakdown on the local administration of education; that they are gearing education down to some medium and not taking care of these top level students.

I have always claimed, in fact, in my own State that they were doing this and that they had better change their method of thinking and start worrying about proper and adequate training for the top level training for the bright or brilliant students.

What interest should the Federal Government have in this problem?

Is this not a local administration of education problem?

MR. OLIVER. To some extent it would be so. First of all, there is a factor of cost in it. There have not been very many places—

MR. GIAIMO. Let me interrupt you right there. If it is not a question of cost, should it not be part of the other problem that the full

committee has as to cost of regular general education; in other words, Federal aid to education, the Murray-Metcalf bill? Should it not be part of general education, because the handicapped are going to be competing, in a sense, for a certain number of dollars?

I wish you would fit the gifted into that group for me, if you can.

Mr. OLIVER. It seems to me that this is in terms of a manpower need, and as such, this particular group is considerably neglected in many ways.

Now, it is true that much can be done at the local level, but a couple of points that I was making was that one of the things that to guide the people at the local level we need some research on a national scale. We need an extension of the U.S. Office of Education to exercise leadership; we need an extension of the NEDA, particularly in titles III and V, to cover this at the elementary level as well as the secondary school level, and in areas other than mathematics, science, and foreign language.

Those would be points in which I think the National Government particularly is interested.

It is not stated in here, either, but it might merit consideration that these United States should set up something which we might call a national academy of mind power in which our best minds would be brought together in research centers throughout the United States.

This would, of course, be at the graduate level; whereas I have been talking primarily about the student in the elementary, secondary, and perhaps early college program.

Mr. GLAIMO. Now, if we get into that field, are we not going to run into the situation where we are going to be charged with taking over local education? If we start a nationwide project to determine what should and should not be done with the gifted, are we not running into the age-old bugaboo that the Federal Government is getting into the field of education? Of course, this is taboo.

Mr. OLIVER. There is possibly this reaction on the part of some people, but I have worked with school committees and with whole school systems all over this part of the United States; in fact, right out here in Summit, N.J., last year.

I find that they are crying out for help and they are not able to get it from the existing agencies.

Their own districts do not have the trained personnel; there is not enough information; there is very little material; there is a lot of a rather superficial nature.

We just are not getting it under the existing pattern. It would seem to me that some coordinated agency both in research and in the dissemination of information would be highly necessary.

Mr. GLAIMO. Are you familiar with Public Law 531, the cooperative research program, that provides aid for research in this area?

Mr. OLIVER. No.

Mr. GLAIMO. I wish you could convince me of why the gifted should be part of this handicapped field because I know that at any time legislation of this type comes up on the floor of Congress, this is going to be one of the great arguments. They will say, "We can understand why you need speech pathologists and speech therapists and we can understand why you need sheltered workshops or half-way houses, and so forth, for the physically and mentally disabled; but we feel

that the gifted problem is strictly one of local education where they are falling down on the job, and we do not see why Federal money should be appropriated for it."

I can see this argument very clearly. Frankly, I cannot see myself in a position to answer it.

Mr. OLIVER. In my opening remarks I tried to anticipate, at least, the use of the terminology that I don't consider these people in the bulk in the area of what you would call handicapped, at least in the usual sense, although I would point out again that there are people who are handicapped in other ways who have fine minds, and that would bring them into both categories.

But if you think of a special education as concerned with the exceptional child and if you think of education as concerned with individual differences—to me this is why I, as a curriculum person, am interested in the problem. We have, for a long time, said that our educational program should be concerned with providing for individual differences and challenging each person at his level, whether he is mentally retarded or whether he is mentally able.

It is just a continuum. If you apply the principle at one end of the scale, I think the principle should be applied equally to the other end of the scale.

Mr. GLAIMO. There is no question what you are saying is so, but the question is which education should apply these principles, local, State, or Federal?

This is where I am in doubt.

Mr. OLIVER. I would simply say that if you can build a case for the mentally retarded and Federal aid, I think the principle behind it is just as applicable to the mentally able.

Mr. GLAIMO. Thank you.

That is all, Mr. Chairman.

Mr. ELLIOTT. Thank you very much, Mr. Oliver.

Mr. OLIVER. Thank you very much for listening to our problem. (The formal statement of Mr. Oliver follows:)

STATEMENT BY ALBERT I. OLIVER, ASSOCIATE PROFESSOR OF EDUCATION, SCHOOL OF EDUCATION, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PA.

THE GIFTED AND HIS EDUCATIONAL NEEDS

I. Introduction

A basic concept of democracy is the worth of the individual. Translated into educational terms, this means the devising of educational plans and opportunities so that we may provide for individual differences of all types and kinds—from the mentally retarded to the mentally able. Increasingly educators and educational groups have been turning their attention to one segment of our student population known as the gifted, generally conceived as those of superior mental ability. I am pleased to have this opportunity to present to you briefly some thinking as a representative of at least three important organizations: That is, I appear before you as president of the Association of Gifted Children, a division of the council of exceptional children, NEA; as past president of the Pennsylvania Association for the Study and the Education of Mentally Gifted; as immediate past president of the Department of Supervision and Curriculum of the Pennsylvania State Education Association.

II. The need

We are concerned about providing a more suitable education for these people known as the gifted. Essentially this involves the proper identification of the gifted, the preparation of teachers to work effectively with these capable young minds, the development of suitable learning materials, coordinated research into

many as yet unresolved problems, the making available of information and help on a national scale.

Although one might make a case that having brains is a handicap, our chief concern is that we consider the gifted to be exceptional children for whom the regular program, regular material, and usual patterns of instruction are not satisfactory.

Manpower studies indicate that the United States wastes much of its talent. For example, fewer than half of the upper 25 percent of all high school graduates ever earn college degrees. A very serious problem in many schools, is that people with high potential ability are not living up to their expectations; these are often known as underachievers. There are too many causes to enumerate here as to why we are not discovering and developing America's mind power, but basically the difficulty could be laid to the failure of our schools to provide sufficiently challenging programs.

There are between 1,500,000 and 2 million gifted children in the United States. While there are some places where programs seem to be operating effectively, nevertheless, the National Man Power Council and the National Education Association estimate that at least 400,000 bright children each year are being denied a chance to develop their potential. The interests of this Nation are tied up with political and social leadership, with the need for effective communication, with people who can develop and promote a philosophic frontier which will guide our destinies. All this is in addition to the well recognized need for leaders in the field of science, mathematics, and foreign languages as indicated in the National Defense Education Act. This latter is a fine beginning step but it is not nearly enough. As Max Lerner has defined the problem, "Our crisis is the crisis of the inadequate use of the potentials of talent and leadership among our young people."

In short, we believe that our gifted are among the most neglected in the United States, and thus we propose the following recommendations for your considered study in providing adequate legislation at the national level.

III. Proposals

(a) *Teacher education.*—It is a truism that "the teacher makes a difference." However, rare indeed is the teacher who has had the opportunity to study the particular problems and procedures connected with education of the gifted. Just as the NEA is providing background for elementary schoolteachers in the field of science; so must we make provisions for teachers in their inservice study to investigate ways and means of meeting the challenge of challenges of the gifted. Just as the National Science Foundation provides scholarships for teachers in the fields of mathematics and science, so must we provide scholarships for teachers to study educational needs of the gifted, in these as well as in many other areas of knowledge. Added to both of these points is the obvious need to recruit and educate teachers in these problems before their actual teaching days. This calls for a carefully developed plan of recruitment and grants-in-aid for the college preparation of such prospective teachers.

(b) *Research.*—An underlying need relates to the matter of getting extensive and coordinated research in many aspects. What kinds of people profit most from what kinds of administrative arrangements? How can we best identify the gifted? How can we motivate each so that he will live up to his potential? What are the attributes of originality, creativity, and critical thinking, and how can these be developed? What are the various kinds of leadership that our Nation needs and how can we provide suitable programs for these goals? How can we evaluate our efforts both through short-range and in long-range studies? Answers to these and similar questions call for a national, systematic research endeavor.

(c) *Matching funds.*—A few States have already begun to encourage experimental programs as well as the improvement of existing plans by providing additional funds on a limited basis. It has been demonstrated that the suitable education for the gifted costs more than for the average pupil—but considerably less than it does to educate those in the handicapped category. Such efforts are not extensive enough in type, spread, or amount. Thus we recommend the development of a plan for matching funds at the national level to encourage activities within the various States, in behalf of the gifted.

(d) The U.S. Office of Education needs to be studied in terms of its function, its expansion of services and personnel so that it may more effectively give encouragement to State and local groups, that it may serve as a clearinghouse to

disseminate information, that it may exercise a strong leadership role in the field of the gifted.

(e) *Extension of the NDEA.*—The commendable work begun through the National Defense Education Act might serve to meet some of the needs of the gifted by extension in various ways. We recommend especially the extension of title V to include the elementary school. We believe that title III should be expanded to give consideration to various other kinds of leadership calling thus for help in the various fields of knowledge beyond mathematics, science, and foreign language—especially the humanities, the social studies, and the arts.

We realize that there is some controversy as to the extent at which education is a Federal responsibility. We do know that several studies have indicated a large majority of people of the United States are in favor of Federal aid to education. If it is of concern to us that moneys and other forms of aid be made available for the rehabilitation of the handicapped, certainly it is equally as important that the same principle be applied to those children and youth of our Nation who are gifted and who, given half a chance, should be providing various types of leadership for our Nation in the future. Such an outcome is dependent upon more money and more leadership than can be provided at the State and the local level.

We respectfully request that the Subcommittee on Special Education of the Committee on Education and Labor of the House of Representatives give serious consideration to the needs of the gifted and to the five suggestions which we have made as to ways in which this critical national need can be met.

Thank you for providing us the opportunity to bring this problem to your attention.

Mr. ELLIOTT. Our next witness is Dr. Marian R. Stanford, Department of Health, Trenton, N.J.

Paul R. Reed?

John Charlton?

Robert C. Thompson?

Dr. Leon Charney?

Are you Mr. Thompson? Come around, Mr. Thompson.

Mr. Thompson is the director of vocational rehabilitation of the Department of Education, Baltimore, Md.

STATEMENT OF ROBERT C. THOMPSON, DIRECTOR, VOCATIONAL REHABILITATION, DEPARTMENT OF EDUCATION, BALTIMORE, MD.

Mr. ELLIOTT. You may proceed, Mr. Thompson, for 10 minutes.

Mr. THOMPSON. Thank you, sir.

I did not bring a prepared statement. I would just like to make a few comments on behalf of vocational-rehabilitation directors.

We feel that this bill, H.R. 3465, is one of the most forward pieces of legislation, forward looking pieces of legislation that has been presented to the Congress in a long time.

It should fill a very great need in the program for the handicapped because under our present plan, as you know, many thousands of persons are so severely disabled at the time of contact that it is not foreseen as to what their occupational outcome may be, so by law we are not permitted to take them on as clients.

This bill, however, would make it possible for us to take on a great many thousands of persons since we would not have to predict vocational success in the beginning.

Now, one of the things that has been disturbing us somewhat in the last 2 or 3 years is the finding of a large number of persons through the old-age and survivors insurance, disability-determination program, who do not seem to be eligible for vocational rehabilitation.

I believe only a small percentage of the folks who are referred to us for determination of disability have any vocational potential at all.

Mr. ELLIOTT. In that field, it seems to me that we need to tighten up our law in terms of making it more workable under the determinations, and particularly those made up recently.

The requirements for social-security benefits for total and permanently disabled were so great, so massive, that I did not find anybody who had ever qualified.

If you tried to rehabilitate all the people that were turned down for social security, you would have a problem on your hands.

Mr. THOMPSON. He certainly would.

There seems to be a little conflict there in the matter of definition. Now, we have, our rehabilitary agency has the determination responsibility, also.

Mr. ELLIOTT. That just occurred recently; did it not?

Mr. THOMPSON. We started out in Maryland with the program. I think all but seven States have a disability vocational rehabilitation.

Mr. ELLIOTT. In Alabama I believe that just occurred in the last 6 months or so.

Mr. THOMPSON. That is right.

Mr. ELLIOTT. I believe that is right, but I will say that you have a difficult job measuring your examination, your determinations, as you call them, with the social security law, do you not?

Mr. THOMPSON. Yes, sir; because of the approach I think in determining what is a permanent disability. In the minds of the social security positions it is complete inability to work.

Now, it is rather difficult in some cases to find persons that you can say are completely disabled, whereas on the other hand, in rehabilitation from the standpoint of the experience we have had, a severe disability is not always necessary to prevent the man from being employed.

A minor disability sometimes makes him unemployable. That is where we have a little conflict.

It is being ironed out gradually because medical consultants in both areas are getting together and I think they have made a great deal of progress lately, but we are still concerned about the large number of people that we can't serve in rehabilitation.

Remember, when the law was passed, it was felt that the majority of them could receive services, but of the 5,000 that we see each year, to make disability determinations on, we get very few of them into the regular rehabilitation mill.

Mr. ELLIOTT. How many do you figure that you rehabilitate, that could be rehabilitated for employment? Others have testified during these hearings that they felt they were only rehabilitating 1 out of 6.

Do you think that you are achieving a higher percentage than that in your State?

Mr. THOMPSON. No, sir; not in ultimate rehabilitation. We serve probably that many, but I don't think we carry them through to successful placement.

Of course, you must remember in these early years of the program they had taken people, patients from mental hospitals and TB hospitals, and all those who had been severely disabled for many years and actually were unemployable.

When that group is cleared out the ones who come in the future will have more potential, but this law would it be possible for us to make, to give extensive evaluation services, to determine a possible vocational potential which we cannot do under the present law.

Mr. QUIE. Do you have jurisdiction over the vocational training of any people? Do you only have jurisdiction over adults, or do you also have jurisdiction over the children in school of vocational rehabilitation or training?

Mr. THOMPSON. Our department of education has a special education service. It was affiliated with vocational rehabilitation up until 1942.

Mr. QUIE. It is not any more?

Mr. THOMPSON. It is not, as such. The same personnel are not there, but we have very close cooperation.

In fact, the school census law, which lists handicapped persons from birth to 21, has a provision whereby all of their findings are turned over to the rehabilitation council.

We also have two or three special counselors now who work only in the school. We make an effort to visit every school at least once a year and we register boys and girls who are disabled as soon as they begin to show a need for vocational guidance.

Now, we do not have any minimum age. It is approximately 16, but we may take persons under 16 if they are beginning to show a concern about them.

Mr. QUIE. Do you have any vocational schools, as such, or are they all classes within the public schools?

Mr. THOMPSON. In the public schools, but not operated by vocational rehabilitation.

Mr. QUIE. Do you have any schools that are strictly vocational schools?

Mr. THOMPSON. Yes, sir; we have several. One of the finest in the world, I would say, is in Baltimore.

Mr. QUIE. Can a person who is a slow learner enter that school, or do you have to have a pretty good IQ?

Mr. THOMPSON. I don't believe they have an IQ provision. They have occupational schools in the city. The city of Baltimore Board of Education is separate and distinct from the State of Maryland, as you probably know. Baltimore City is one of the 24 political units.

The other three being counties, so that it has its own school system.

Our program of vocational rehabilitation is probably the only educational program that is covered statewide. We use the schools, but we pay tuition for persons that come into it from outside the city of Baltimore.

Mr. ELLIOTT. Thank you very much.

Mr. THOMPSON. Thank you, Mr. Chairman.

Mr. ELLIOTT. The subcommittee will adjourn now until 2:15. We will resume at 2:15 with the witnesses scheduled for this afternoon.

(Thereupon, at 12:35 p.m., the subcommittee was recessed, to reconvene at 2:15 p.m. same day.)

AFTERNOON SESSION

The subcommittee reconvened at 2:45 p.m., upon the expiration of the recess.

Mr. ELLIOTT. Our genial host, Congressman Dominick Daniels, fed us so well this afternoon that we could not get back in time to meet our starting time, but we will get going now.

Our first witness is Dr. Marian Stanford.

Is Dr. Stanford here?

May I say to you now that we have 15 or 20 witnesses to hear this afternoon. We must limit our witnesses to 10 minutes.

With that understanding, you may proceed.

**STATEMENT OF DR. MARIAN R. STANFORD, DEPARTMENT OF
HEALTH, TRENTON, N.J.**

Dr. STANFORD. If you will give me a little signal, I will appreciate it.

I am director of the division of chronic illness, State department of health.

It has been said that problems are only opportunities in work clothes. New Jersey has already put on its work clothes and is today working toward the solution of the problem of chronic illness.

In the spring of 1952 the prevention of chronic illness act became law. This act established within the State department of health a division of chronic illness control for the prevention, early detection, control, and rehabilitation of chronic sick of this State.

Now, I should like to have a copy of this law in the record, because it is, I think, a very forward-looking law.

Written into this act is a declaration of public policy which states that:

The growing problem of prevention, detection, and care of chronic illness, which is of such character as not to be exclusively medical, educational, or welfare, has now reached such proportions in this State as to require the participation of the State and of the agencies administering public health, education, and welfare within the State and it is hereby declared to be the public policy of this State that the responsibility therefor must be shared by the State and the counties and several municipalities and health districts and the voluntary agencies and institutions within the State, and the public at large.

This amounts virtually to mandate from the citizens of the State through their elected representatives for a coordinated program of chronic illness control with the process of coordination operating both horizontally and vertically from the State to the local area.

The problem of chronic illness is so complex in nature, so diversified in need, and so widespread throughout all population groups that only through the combined efforts and the best efforts of all of us can we make any appreciable headway in promoting and emerging new concepts of health.

The health of the individual is no longer evaluated in relation to a disease entity, but in terms of physical fitness mentally, emotionally, and physical adjustment, as a means to a happier and more productive life.

The division programs are developed around the total person and our emphasis on his capabilities rather than his disabilities.

The attainment of this higher standard of health requires the assistance of many different disciplines in a well-coordinated team approach, but the complexity of problems and the multiplicity of needs of the

chronically ill individual make it impossible for a physician to carry the burden unaided.

Assistance has been given in the development of community hospitals as diagnostic and consultation centers to which the private physician may refer patients for the highly specialized techniques which are impractical or impossible to carry out in his office.

We have planned training programs for the physicians, provided equipment and grants for personnel in order to apply the new knowledge that is now available in the prevention of many chronic illnesses.

The family physician initiates the planning and participates in the evaluation process with the hospital team of professional and technical specialists which may today include physical and occupational therapists, hearing and speech therapists, physicists, and psychologists.

Grants-in-aid have been given to hospitals to build in these skills so essential to total patient care. We are proud that New Jersey has been a leader in this comprehensive approach and anticipatory planning in the hospital.

The method of encouraging local agencies, usually community hospitals, to initiate programs by providing financial assistance through grants-in-aid contracts seems to be an effective way of gaining community interest.

The contract places responsibility on the operating agency at the onset for the operation of the program and clearly indicates that the financial assistance given by the State is temporary.

Services far in excess of the actual expenditures of State funds have been provided for the people by this method of aiding agencies already operating a service to the public.

To illustrate, the restorative service unit of the Essex County Hospital, Belleville, opened May 1, 1955, as a State-county pilot project to demonstrate that a health facility for which there has been a decreasing need as a contagious disease hospital, can be put to work as a disability reducing unit.

A study was made after 31 months of operation of this program and revealed that 103 of the 177 persons in this restorative unit who had been in this restorative unit who had been in this restorative unit were still alive.

Fifty-three were in their own homes and none was in hospitals.

There is a detailed study of this in a pamphlet which I have placed over there which was prepared by Miss Audrey Ann Duffy, our State consultant in medical rehabilitation.

I am going to skip some of the findings, but I would like to say that this study demonstrated that the cost of community placement after registration for these patients was only one-half as great as custodial care would have cost.

This study shows that there was a savings in that 31 months of \$600,000. And individuals were placed in a more homelike environment and that is essential for these patients to thrive.

We would like to see this kind of facility in every county.

Our greatest problem is that we cannot get the skilled personnel. They don't seem to exist. We anticipate the development of an out-patient service at the Belleville Hospital where these patients may return for periodic evaluation.

There, again, it is essential to have these facilities available so that the individuals can get from their home to the facility readily.

I would like to give you an example, if I have the time, of one or two cases there.

A 51-year-old woman with a history of arthritis and periodic hospitalization for mental illness since 1937, was admitted for comprehensive evaluation in the restorative service unit at the Essex County Hospital. The final diagnosis was conversion hysteria. Her illness was not caused by disease, but by emotional problems.

Warmth and support services and a limited program of intensive therapy to demonstrate to the patient that she did not have arthritis, but had the muscle strength, resulted in stimulating her to really work to get back on her feet and to return home.

She had received assistance from public sources since 1937 because she had been incapable of self-care of managing her own home.

Now, the patient is healthy, happy, and independent after only a short period of hospitalization and restorative service unit.

Now, the second case I would like to tell you about and that about winds it up.

The very, very first patient admitted to this restorative unit when it opened in 1955 was an 84-year-old widow, a stroke victim. She is still alive, she is still living alone, and all of the community supportive services she has needed has been a homemaker for a few hours a day.

She now needs only a chore boy to do some shopping and various things.

All it costs for her to live alone was an adaptive device which cost \$15. She had 60 days of intensive restorative treatment in the unit.

Our greatest need is to apply the knowledge that we have today to prevent many of the complications that we are now seeing.

Our greatest need is more skilled personnel and a flexible program for training personnel. I believe we will have to recruit while the students are still deciding on their life careers.

I would like to close by quoting Leonard W. Mayo, chairman of the National Commission on Chronic Illness:

Herein lies the problem and the challenge of chronic illness and disability. No one agency, no one profession, no one program can prevail. Nor can 50 national, or any number of local agencies, working separately, prevail. The prognosis calls clearly for the most extensive, complete, and effective unity of forces ever undertaken outside of war in our history.

Thank you.

Mr. ELLIOTT. Thank you very much, Dr. Stanford.

(The statement and pamphlet referred to follow:)

STATEMENT SUBMITTED BY DR. MARIAN R. STANFORD, DEPARTMENT OF HEALTH,
TRENTON, N.J.

It has been said that problems are only opportunities in work clothes. New Jersey has already put on its work clothes and is today working toward the solution of the problem of chronic illness. In the spring of 1952, the Prevention of Chronic Illness Act became a law. This act established within the State department of health "a division of chronic illness control for the prevention, early detection, control, and rehabilitation of the chronic sick of this State." Written into this act is a "declaration of public policy" which states:

"The growing problem of prevention, detection, and care of chronic illness, which is of such character as not to be exclusively medical, education, or welfare, has now reached such proportions in this State as to require the participation of this State and the responsibility therefor must be shared by the State and the counties and the several municipalities and health districts and the voluntary agencies and institutions within the State and be public at large."

The law further provides that the division shall arrange for joint discussion of the general problem of the chronic sick with representatives of all official and voluntary agencies and professions for the "purpose of formulating an adequate program for dealing with the problem of the chronic sick, and to determine a formula for the ultimate division of the governmental share of the cost thereof between municipalities, counties, and the State."

The division of chronic illness control has planned its program on the assumption that no one department, group, or organization can do the job alone. The problem of chronic illness control is so complex in nature, so diversified in need, and so widespread throughout all population groups, that only through the combined efforts—and the best efforts—of all of us can we make any appreciable headway in promoting an emerging new concept of health.

The health of an individual is no longer evaluated in relation to a disease entity, but in terms of physical fitness and mental, emotional, and social adjustment as a means to a happier and more productive life. In other words, our division programs are developed for the total person and our emphasis is on prevention of disability and/or the preservation of his capabilities rather than his disabilities. The attainment of this higher standard of health requires the assistance of many different disciplines in a well-coordinated team approach.

Let us keep in mind also that the development of official and voluntary health programs does not alter the fact that primarily it is the family physician upon whose shoulders rests the responsibility for the health of the individual and his family. But the complexity of problems and the multiplicity of needs of the chronically ill individual make it impossible for the physician to carry the burden unaided.

Assistance has been given in the development of community hospitals as diagnostic and consultation centers to which the private physician may refer patients for the newer highly specialized techniques which are impractical or impossible for him to carry out in his office. It is only in physicians' offices and in community hospitals that essential services can be brought to the patient at the earliest possible time. The family physician initiates the treatment plan for the patient and usually participates in the evaluation process with the hospital team of professional and technical specialists which may today include hearing and speech, physical and occupational therapists, nurses, medical social workers, biochemists, physiologists, physicists, and cytologists. Grants-in-aid have been given to hospitals to build in these skills so essential to total patient care. This is prevention.

We are proud that New Jersey has been a leader in the promotion of the comprehensive approach to more positive health through anticipatory planning for the patient starting in the community hospital. It is only by anticipating complications which may arise with a particular illness, and taking steps to prevent such complications as soon as possible after the diagnosis is made, that people can be directed toward partial or complete self-help at the beginning of their trouble. If there are delays, people are robbed of that opportunity as they lose more of their health or their initiative and self-reliance.

Through mass screening programs and selected screening of patients in hospitals, unsuspected disease or incipient disease can be brought to the attention of physicians and, again, their role is the key one in making the definitive diagnosis and providing adequate treatment, as early as possible to prevent unnecessary disability.

The method of encouraging local agencies, usually community hospitals, to initiate programs by providing financial assistance through grant-in-aid contract places responsibility on the operating agency at the onset for the operation of the program and clearly indicates that the financial assistance given by the State is temporary. Services far in excess of the actual expenditures of State funds have been provided for the people by this method of aiding agencies already operating a service to the public.

To illustrate, the restorative services unit at Essex County Hospital, Belleville, N.J., opened on May 1, 1955, as a State-county pilot project to demonstrate that a health facility, for which there has been a decreasing need as

a contagious disease hospital, can be put to work as a disability reducing unit and/or prevention center. This project developed after months of joint planning by the division of chronic illness control staff and the Essex County Board of Chosen Freeholders in cooperation with the Essex County Welfare Board and the Essex County Medical Society. This restorative services unit provides a comprehensive program of professional services (psychiatrist, psychologist, nurse, medical social worker, occupational therapist, physical therapist, and vocational rehabilitation counselor) to marginal public assistance recipients.

A recent evaluation of this program after 31 months of operation illustrated the degree of restoration attained in a group of 177 persons ranging from 27 to 94 years of age. The study revealed that 103 are still alive; 53 are living in their own homes, the remainder are in nursing or boarding homes, and none are in the hospital. The average length of stay in the Essex County Hospital was 58 days, ranging from a period of 8 days to 165 days. Following restoration and placement in a more homelike environment, documented cost per patient fell from \$300 to \$104 a month, with an average saving of \$196 per patient per month. The cost of community placement proved to be only one-half as much as custodial care for the same period of time, while return of the patient to his own home cut the cost to one-quarter of that required for custodial care.

A similar restorative services program is in operation at the Camden County Hospital where the county board of freeholders has taken over all financial responsibility for the team of skilled workers after 3 years of assistance from the division of chronic illness control. A program is developing in Trenton at the Donnelly Memorial Hospital, and a former almshouse in Sussex County. This program will ultimately be expanded to a county level. Planning for similar programs in several other countries is underway. Patients thrive better in their familiar environment and where they can return to the hospital for periodic reevaluation with a minimum need for transportation.

INSTITUTIONALIZATION BECOMES UNNECESSARY

The first patient admitted to the Essex County Restorative Service unit in May 1955 was an 84-year-old widow, a stroke victim, who is still alive. After 2 months of intensive restorative therapy she was discharged to her own home. Now, 5 years later she is still living in her home. An adaptive device costing \$15 enabled her to maintain herself in her own home on a public assistance grant of \$82 a month. Her only community supportive aid was a homemaker service for a few hours a day for awhile and now she needs only a chore boy occasionally. Continued custodial care for this period of time would have cost \$17,100 and she would still be helpless. Her actual living cost since discharge has been \$4,510.

A MAN LEARNS TO WALK AND TAKE CARE OF HIMSELF

A nonambulant, male patient age 40 years who had experienced hospitalization on and off since 1944 was referred to the restorative services unit at Camden County Hospital on October 18, 1957. During a series of treatments over a period of 1 year and 10 months, the patient's condition showed marked improvement, and so did his motivation to help himself. Under supervision he was able to learn to walk again and care for his own needs. The time spent in the hospital as an inpatient was 14 years, 39 weeks, and 2 days at a cost of \$25,643.67.

A FAMILY REUNITED

A 51-year-old woman with a history of arthritis and periodic hospitalization for mental illness since 1937 was admitted for comprehensive evaluation to the restorative services unit at Essex County Hospital. The final diagnosis was "conversion hysteria." Her illness was not caused by disease but by emotional problem. Warm, supportive help and 37 occupational therapy treatments helped to motivate her to cooperate and to realize that she could perform all activities of daily living. This patient had received assistance from public sources since 1937 because she felt incapable of looking after herself and her home. Now she is healthy and happily independent after a period of only 5 months of participation in the restorative services program.

Much has been accomplished through our restorative service programs to give hope, better health, and more enjoyable living to those individuals who were at one time regarded incurable. Our greatest handicap is lack of skilled

personnel. We need training programs to prepare a greater number of skilled personnel and to train others who can work under their supervision. Recruitment for special training should be done while high school students are considering their life careers.

ARE RESTORATIVE SERVICES FOR THE AGED A GOOD INVESTMENT?

(By Adriane V. Duffy, M.S., fellow, American Public Health Association, program coordinator, public health social work program, New Jersey State Department of Health, in collaboration with Dr. Marguerite F. Hall, Ph.D., fellow, American Public Health Association, vice chairman, Public Health Research Project Design and Evaluation Committee, New Jersey State Department of Health)

The preservation of priceless human values which can result from an intensive program of restorative services for aged chronically ill individuals has been dramatically demonstrated many times in regained human dignity and the ability to become self-sufficient. Because many local communities are not aware of the dollar value to be received for the dollar spent—believing these programs to be too expensive to develop and support—relatively few have been established. Expenditures of public or voluntary funds on bedridden individuals and long-term residents of nursing homes or other institutions, in what seems to many to be their nonproductive years of life, have been considered a poor investment, offering little or no economic return to the community.

GRANT-IN-AID METHOD INCENTIVE FOR COMMUNITIES

In New Jersey, the grant-in-aid method of State assistance has been a productive way of fostering the establishment of needed community services. Responsibility always rests with the local agency, and it is understood from the outset that the financial assistance from the State will be reduced on a year-by-year basis. The State Department of Health both lends expensive specialized equipment and also provides financial grants-in-aid to permit employment or training of specialized professional or technical personnel. In effect, the grant-in-aid is an incentive or motivation acting as a catalyst in the community.

The restorative services unit of the Essex County Hospital, Belleville, opened on May 1, 1955, as a State-county pilot demonstration project. It was the result of months of joint planning by the division of chronic illness control of the New Jersey State Department of Health and the Essex County Board of Chosen Freeholders (the elected officials of the county government) in cooperation with the Essex County Welfare Board and the Essex County Medical Society.

Decrease in recent years in the incidence of communicable diseases for which the Essex County Hospital at Belleville had originally been built made available to the Essex County Welfare Board the first unit of 25 beds. The restorative services unit had its base in the new concept of the functional restoration of the aged chronically ill individual to his maximal functional capacity. Its goal was the development of the individual's capacity toward self-care rather than "vocationally directed" goals. This involved a variety of professional skills and supporting community resources, including the physical therapist, occupational therapist, medical social work coordinator, the liaison department of public welfare caseworker, and the public health nurse in the community. The medical social work coordinator was responsible for integrating the planning for the patient in the hospital and the community.

The medical advisory board of the hospital and of seven community hospitals both public and voluntary, offered services of their consultant medical staffs on a 3-month rotating service.

TEAM ASSESSED PATIENT'S CAPACITIES

Admission to the hospital was based on an acute episode suffered by the patient, such as a fractured hip or other functional disability. Admission of patients to the restorative services unit followed team assessment of the patient's functional capacity and potential for restoration. Many of the patients had a long history of hospitalization, and most were bedfast or chairbound.

After 31 months of operation, the Essex County Board of Freeholders and the State department of health both requested that an evaluative study be made by the State consultant of the public health social work program, work-

ing in close cooperation with the Essex County Welfare Board, to assess whatever gains had been made by the patients admitted to the restorative services unit. The study period was limited from May 1, 1955, to January 1, 1958. Administrative channels were cleared and steps were taken to facilitate the study. By agreement with the county welfare board, the case records and audited financial statements were made available to the State consultant, in order to document total costs of patients in the study who had been admitted to the restorative services unit. The study was based on the tentative hypothesis that restorative services for the aged chronically ill patient both rewarded the patient and aided the community in dollars saved.

177 PATIENTS ADMITTED IN 31-MONTH PERIOD

During the 31-month period, 177 patients were admitted, including 128 who received old age assistance, 47 receiving disability assistance, and two in the blind assistance category. Ages ranged from 27 to 93 years.

Identification data were secured from the admission register of the restorative services unit, the hospital chart furnished medical information, and the individual case record of the county welfare board was the source of detailed placement costs. All costs were entered from audited records. The unit in the study was the individual admission of a patient to the unit.

A preliminary sample of 20 admissions was completed for evaluative purposes, to assess information available. In conference with the public health statistician, a revised schedule was devised, dividing the history of the patient's placement into four phases: the preadmission phase, the hospitalization-restorative phase, the postrestorative phase, and the present status as of January 1, 1958. Using the revised schedule, an analysis of 188 admissions of the 177 patients was completed. Admission and discharge status was determined in conference with the restorative services team.

A series of conferences with the county welfare board caseworker assigned to the public assistance clients in the hospital was held to document all costs for preadmission, community placements, the Essex County Hospital period of hospitalization, including the restorative services period, and the cost of placement by type and length of stay in the community up to January 1, 1958, on a case-by-case basis.

After the information on the 188 admissions was assembled, the public health statistician prepared instructions for coding the items on the schedule. Specific directions related to the seven time intervals related to cost as shown in the schedule were given for business machine processing. The interval for each patient was analyzed from the date of admission to the hospital to the cutoff date of the study or death of the patient.

HOSPITAL COSTS COMPARED WITH COMMUNITY PLACEMENT

When all data were collected and processed, all monthly rates were converted into common denominator per diem rates. The \$10 daily comprehensive rate charged at Essex County Hospital remained constant throughout the study and was the basis of comparison. Total costs of hospitalization, of restorative services unit, and of prosthetic aids were determined. The cost of individual community placement was calculated by type of placement and length of stay. The total cost for restoration of the patient in the hospital was then compared to the type and cost for community placement and the length of time the patient had survived in the community.

Of the 177 patients involved in the 188 admissions, 143 were still living; 45 had died during the time span of the study. There were 19 patients still under care in the unit and 156 had been discharged to a community placement. Of the 45 patients who died, 9 died in the hospital. The remaining 32 patients had a survival period ranging from 1 to 28 months. There were twice as many females as males admitted to the unit. Ten patients had more than one admission; nine were admitted twice and one was admitted three times.

Excluding the patients who died either in the hospital or community, of the remaining 143 patients, 75.5 percent were bedfast on admission but only 2.8 percent were bedfast on discharge.

There were six major groups of disability. The largest, 38 percent resulted from cardiovascular disease, including "strokes"; 21 percent were admitted because of fractures; 20 percent were amputees, the majority of which were a

result of diabetes; and the remainder were related to arthritis and neurological disability.

As an illustration of a cost analysis of an admission, the following is offered: Sixty days of restorative therapy at a cost of \$10 a day to the county welfare department, plus \$90.50 for prosthetic devices (a total of \$690.50) enabled a 70-year-old "stroke" patient who was previously bedfast to return home. The cost of her maintenance since she returned to the community has been \$2.83 a day for the past 934 days. She was the first patient admitted to the unit. Since this patient is still alive and living in the community, the savings continue at the same rate each month.

SERVICES REFLECT LARGE ECONOMIES

Preliminary analysis has shown that the 177 persons admitted to the hospital spent approximately 879 patient-months under care at a total cost of \$263,700. Subsequent to their discharge, \$205,900 was spent for their care in various types of community placement. For restorative aids, such as canes, etc., \$4,850 was spent. The State invested \$22,000 in grant-in-aid funds during this period. If the 1,986 patient-months of care provided in community placement had been spent in the Essex County Hospital under custodial care, the cost would have approached \$600,000. The restorative services provided and community placement achieved resulted in a saving of approximately \$400,000. Documented costs per patient fell from \$300 a month to \$104 for an average saving of \$196 per patient per month.

However, this does not reflect the total hidden savings to the community in terms of the true hospital per diem cost, since the flat \$10 per diem is only about half the cost per patient bed. Since 22 percent were admitted from community hospitals, the costs for this group would be greater. In some cases, there was a time lag between hospital discharge and community placement due to limited community resources which, if available, would have further increased the amount saved. Following restorative therapy, 64 percent of the patients admitted were cared for in a less expensive placement.

The findings in the study have stimulated community action in several areas. Time lag between discharge from the restorative services unit to community placement has been reduced through simplification of competitive bidding for prosthetic devices. An outpatient clinic is being established at this hospital, and a bus is to be purchased to transport patients to the unit for periodic reevaluation. The total caseload of 6,000 individuals receiving public assistance from the county welfare board is being reevaluated to discover potential candidates for restoration.

The challenge in this field of restorative services for the aged is that valid knowledge and medical techniques are now available. We do not have to wait for research to make new discoveries. Knowledge exists but it needs to be applied. What we need is the instrument which will make these services available to people. The pilot project in New Jersey, stimulated by the State's participation and based on a great community need, has proven that it is good economics and sound social planning to invest money and professional skills in the restoration of the disabled.

Mr. ELLIOTT. I recognize now the gentleman from New Jersey, Mr. Daniels.

Mr. DANIELS. Mr. Chairman, we are privileged to have with us this afternoon the mayor of one of our neighboring municipalities, the city of Bayonne, located in the 13th Congressional District, represented by my colleague, Cornelius Gallagher. I am privileged to present to you Mayor Brady, of Bayonne, N.J.

Mayor BRADY. In view of the fact that a whole lot of people here are in long distances and they have had a difficult time traveling, Dr. Merity, superintendent of schools of Bayonne and Dr. Horgan, director of special education of Bayonne, would like to hand in their reports for the record.

Mr. DANIEL. Thank you very much.

I would like to say, supplementing my previous remarks, that Mayor Brady is the father-in-law of one of our distinguished

colleagues from the State of Connecticut, the Honorable John Monagan.

Mr. ELLIOTT. I am happy to meet you.

Without objection the statements of the mayor and his associates will be made a part of the record at this point.

(The statements referred to follow:)

STATEMENT OF HON. ALFRED BRADY, MAYOR, BAYONNE, N.J.

The need for expanding our program in education to meet the requirements of our special education has been fully demonstrated. We all recognize it. Such a program requires continuous research. The cost of operating and improving such facilities as our research indicates will be a continuous and increasing expense.

The economy of our city and of most New Jersey districts is already being strained to meet the increasing costs of education which are now considered normal.

The problem is countrywide and worthy of the full consideration by the Federal Government. I hope that you gentlemen will recommend the following:

1. The expansion of the Federal research facilities in the field of special education.

2. Continuing guidance for the States resulting from the research results.

3. The provision of sufficient Federal aid to enable the school districts all over the country to implement the research results.

STATEMENT BY DR. CORNELIUS M. HORGAN, DIRECTOR OF SPECIAL EDUCATION AND SCHOOL PSYCHOLOGIST, BAYONNE, N.J.

Please accept my heartfelt thanks for the privilege of appearing before your distinguished committee and discussing our problem of meeting the challenge of special education. Today, community leaders from our city are appearing to discuss local needs with you gentlemen who have the responsibility of solving problems of broader scope and of deeper national impact.

Since the committee has heard and recorded testimony covering all aspects of special education and rehabilitation; and since the committee is well aware of the relative importance of research, training, therapy, service extensions, etc., we are limiting our presentation to suggesting how the governing body can aid us in solving a local problem. In appearing before your body and presenting our recommendation, it is hoped that constructive action may bring a solution to our situation and pave the way for other communities in our State in finding an answer to the paradox of extending special educational services and facilities in the face of shrinking sources of financial income.

Our superintendent of schools, Dr. Howard E. Merity, is appearing to stress the need for assistance in educational planning for a public-school population of over 8,500 pupils, in terms of the special education problem. National estimates of the extent of the problem of the handicapped would indicate that considerably more children are in need of specialized services than those presently enrolled in the classes for the mentally retarded, educable and trainable; physically handicapped; and the homebound.

Our mayor, Hon. Alfred E. Brady, will indicate the influence of budgetary pressures on present and on projected educational planning. In the past, many of our special-education personnel were encouraged to qualify for certification in special education, when the board of education reimbursed them for tuition costs; and in addition, granted bonus-increments. In recent years, budget problems caused a curtailment of those and other inducements to teacher preparation and to the extension of any educational program for the handicapped.

On the other hand, State legislation has extended services not only for the physically handicapped and the mentally retarded, but also includes the socially maladjusted and the emotionally disturbed in the special-education format. Within the framework of the program of the State department of special education, child-study specialists and services have been introduced. These child-study services are an important and necessary element in any complete and comprehensive program that attempts to meet the needs of all children in the

educational scene—whether they are in the regular classroom population, or actually participating in a special-education program.

After more than 25 years of experience working among the mentally handicapped and physically disabled, as a teacher, supervisor, administrator, director, and school psychologist, and more than 10 years as an instructor in special education on the university level, I am firmly convinced that the only solution to our local problem, and to the problem of other adjacent communities, is by direct financial assistance from the Federal Government, with respect to two specific areas: respectively, space needs and specially trained personnel.

It is recommended that your committee study the feasibility of extending financial assistance to our community for construction of a child-study and training center that will be designed and equipped to effect a complete program of diagnosis, therapy, counseling, and training of all types of deviates, and disabilities. Such a center would enable our community to meet the needs of the handicapped in an efficient, professional, and humane manner and, in addition, meet the provisions of the State law with respect to special education.

Plans for such a center and the specific program included in the specially designed space have been the topic of many months of consideration by professionals, civic representatives, and my membership of our Parent-Teacher Association for Special Education. Committees have visited other community special-education facilities and plants in order to more efficiently plan for the future. Other witnesses scheduled to appear before this committee are concerned with this problem and they will indicate to the committee their ideas and suggestions to implement my recommendation.

I wish to thank the committee for the time extended to me to present this simple recommendation. It is hoped that the brevity of this report will not oversimplify the magnitude of this problem that I have lived with for over a quarter of a century. It is hoped that Federal assistance will enable us to adequately provide for suitable facilities for the handicapped in our community.

STATEMENT OF DR. HOWARD E. MERITY, SUPERINTENDENT, BAYONNE PUBLIC SCHOOLS, BAYONNE, N.J.

Honorable sirs, please be assured of my gratitude to the honorable members of the committee for this opportunity to express my convictions on our present situation in special education. I have the honor to be the superintendent of schools in a city of 77,000 (according to the 1950 census) maintaining 11 elementary schools and a comprehensive high school and educating 8,700 students.

Our Bayonne school system has been conducting classes in special education for about 40 years. In view of this accumulation of experience it would seem that we should have the situation well in hand. We have to admit that our perplexities in this important field of education have increased much faster than our solutions for them. In fact our situation has reached the crisis stage which makes it imperative that Federal funds be available. This is a problem faced by all superintendents today. It is not merely local or rural or urban. It is common to all school systems, therefore national.

We have a very intense and acute awareness of what we lack. We have a very accurate and concrete knowledge of what we need. With our present financial means we cannot see our way clear to provide adequately and justly for all the boys and girls who should be benefited by this program. It is heartening and encouraging that the honorable members of this committee are giving us this opportunity for a public hearing on special education. In addition to what the specialists have already outlined for you as the necessities of this area of school work I appreciate the privilege of pinpointing our own quandary.

All the current discussions on city and school budgets bring out the fact that it is practically impossible to raise additional funds for educational purposes under the present property tax system, however urgent these purposes may be. In Bayonne we are able to provide for the physically and mentally handicapped only to a very limited extent. I am not very happy in stating to you that our present special education classes alleviate the anxieties and worries of too few parents of too few handicapped children. For every such child that we are able to take care of in our setup there are several more scattered through regular classrooms which are unsuitable for them. For the most part we can provide only for the more severe cases. Too often the selection of transfer has been affected by extreme behavior problems or extreme physical defects, rather than a

well-planned, well-implemented, complete transfer of all who need a training matched to limited abilities. Hence many such children are right now being deprived of the type of training that is suitable for them. I am actually compelled to hold down the enrollment in our special education classes in conformity with the number of teachers and classroom facilities that we can afford under our current budgets. The Beadleston legislation in New Jersey is founded on noble objectives and a comprehensive viewpoint, but we must frankly confess that we do not have the resources to carry out its wise and just provisions.

We are all aware that teachers for these special education groups must be well selected and well trained for their important work. We have never expected the regular classroom teacher to be equipped to cope with the problems of the special class. Back over the years we have offered special inducements to selected regular teachers to enter special education by such means as extra salary increments, reimbursement for courses taken, etc. Unfortunately, we even had to eliminate these. And even if we had the money for the salaries of the additional teachers needed, we would still be limited by lack of space in our present special education facilities.

Therefore, I am one of a multitude of superintendents who find ourselves between two milestones. On the one side is the reasonable and professional pressure exerted upon us by teachers and principals to provide for all the children who need special education. On the other side is the concrete reality that sufficient funds are not available. Our teaching faculty and our parents are unanimous in acknowledging and deploring our limitations in special education provisions in Bayonne and are cognizant of the economic limitations causing this.

This is a brief summary of the reasons why I consider it a privilege to appear before the honorable committee, and why I earnestly recommend Federal participation in these programs designed for our physically and mentally handicapped boys and girls in Bayonne and especially for those whom we have not yet been able to bring into the benefits of the special educational program.

Mr. ELLIOTT. Thank you very much.

Are there any other people from Bayonne?

Is Joseph Bagley here?

We will hear your testimony now, sir. Mr. Bagley, you may proceed, subject to our limitation of 10 minutes.

STATEMENT OF JOSEPH BAGLEY, CHAIRMAN, KIWANIS SPECIAL EDUCATION COMMITTEE, BAYONNE, N.J.

Mr. BAGLEY. Gentlemen, I am not an educator. I am a member of a special education committee of the Bayonne Kiwanis Club.

This committee has been active on and off for the past 7 years in the field of special education. In the past 12 months the committee members have spent 50 man-days and have traveled some 2,200 miles.

We have visited the Halloran School in Elizabeth and the junior school in Camden. We have talked with parents, teachers, principals, and superintendents whenever possible.

We established a need for special education through the good offices of Dr. Merity and his principals.

Dr. Boyd Nelson, director of special education in this State aided in developing a plan for the educable and the trainable in Bayonne School District.

Dr. Westby, head of school construction in this State, assigned Dr. Spare one of Dr. Westby's assistants in school construction to determine the space needed for 25 classes of educable, trainable, physically handicapped, socially maladjusted, and educationally maladjusted children.

Dr. Spare and Dr. Boyd Nelson took care of the problem of the space requirements as demanded by the laws of the State of New Jer-

sey; 60,000 square feet of school space with the facilities that go with type of project is needed. This is the actual space needed for minimum requirements in the Bayonne School District.

Approximate cost of building and facilities, \$1,500,000. Bayonne like many communities in the country needs Federal aid and State aid to maintain a high level of learning.

The magnitude of the growing workload in the field of special education is such that a pilot plant will have to be set up as a pattern for others to follow in the State and in the Nation.

It is the Bayonne Kiwanis Club's hope that you gentlemen will see to it that our dream of a pilot plant for Bayonne will be realized.

These sketches are not drawn to scale, but the estimated footage is quite accurate.

Mr. ELLIOTT. Thank you very much, sir.

I recognize the gentleman from Minnesota, Mr. Quie.

Mr. QUIE. Have you gone before the State legislature to give them the views of Kiwanis of what you ought to do to promote more aid for special education in schools?

Mr. BAGLEY. No, sir. What we did do was to work in a way that Dr. Nelson, who heads special education in the State; Dr. Chase, who is the county supervisor of education, and Dr. Meridy, who is the superintendent of the school district—we kept in line with each other in the sense that any changes made in this plan that we have developed with the aid of all these men just so it would be mutually agreeable all around.

We have not as yet presented it to anybody other than you people.

Mr. ELLIOTT. Thank you very much for your testimony.

Mr. DANIELS. Our next witness is Mr. Harry R. Bloom, of Bayonne.

Mr. Bloom, you are familiar with the rules of the committee that because of the large number of witnesses who have asked to appear here today to testify, we must limit the testimony of the witnesses to a period of 10 minutes?

STATEMENT OF HARRY R. BLOOM, BAYONNE, N.J.

Mr. BLOOM. Mr. Congressman, I am familiar with your rules.

May I say this, I think that all of you deserve a vote of thanks for coming into our area to listen to the problems that are being presented to you.

As to Mr. Quie, of Minnesota, I address this remark: I think he should be very proud because the National Association for Retarded Children was organized in Minnesota 10 years ago in Minneapolis, and I was there as one of the organizers. This was a group that was formed by parents and not by professional people.

I speak here as a parent and as one who has been interested in this problem for a period of possibly 15 to 20 years. It is gratifying to know that the problem at last is coming to the front.

It is gratifying to know that at last the problem, which is one of the great problems in education in the country, is being recognized for what it is.

I am a layman. I am an attorney, and I do not speak with the authority and case reports that some of the people who are present here and who spoke to you yesterday, have. I speak as one who

has seen this problem and who over a period of years has found that there are many lacks and there are many paper projects which in reality never function.

There are problems of trained personnel, and without trained personnel the number of buildings and bricks and mortar that you might furnish in a very simple manner by making an appropriation, will not fulfill the problem. The problem is one of training personnel so that there will be a group of people to take care of the problem when it is present, as it is.

There are needs for buildings. There are needs for workshops. There is a crying need for trained personnel, teachers, and others, who can meet the need, the challenge, for the training of these retarded children and those who are mentally handicapped.

It is simple to say, "Why not become a teacher for the mentally retarded?" This in itself is not an answer. The problem is one of assistance to those who are interested in the problem because, frankly, it is a job which in many instances is challenging and tiring job as all of us do, we seek to do the easiest thing rather than the most difficult thing.

So that if it becomes necessary to help them with grants so that they can take special courses and so forth this kind of problem must be worked out.

The burden on the families might be relieved by certain tax concessions so that the families will be able to take care of their own in a much more efficient, possibly, and cheaper way, than in merely seeking large institutions for the purpose of institutionalizing and so on.

There is a problem of recreational facilities. There is a problem of training these retarded, mentally handicapped people to do the things that they are capable of doing and making their own contribution within their own ability in the civilization in which we live.

These, in many instances, are the forgotten children, but thank God for a committee such as this, and thank God for the action which has been taken over the past 10 years. They are not being forgotten now.

There are problems of psychological and psychiatric assistance. In many school systems we do not have adequate facilities because, unfortunately, they are bogged down with the budgetary problems of the normal. There isn't enough money, as we all know, in some of the budgets, and this is the cry, to even take care of the students who are actually there.

There is this constant attempt to cut down. When you are in the field of special education where 1 teacher will take care of 10 pupils, this throws the ratio, which on paper does not look good—it throws it out. So that this might be costing the system more than one who could be teaching 30 children.

These are the practical problems that parents face and the practical problems the taxpayers face in trying to get this kind of problem right at the ground roots level, where it belongs in the school system, in the home, in the assistance that is required in this area.

Many of these children come from parents of limited circumstances. These are the parents that sometimes might need tax relief if they were to provide medical attention rather than send the child to an institution where the same medical attention might cost a great deal

of money and, certainly would not be as concentrated and as important as under the parental supervision.

I want to again thank you gentlemen for listening to the stories that you heard yesterday. Much of it is technical. I feel privileged as a parent and who is interested to appear before you. I feel that I speak for thousands of parents who might not be as vocal as I am and I say that the problem is one of great severity. It is a problem that must be faced as a practical one.

When I say as a practical one, if it is faced in its inception with a view toward a preventive approach, it may in the long run save many taxpayer dollars in the future.

Thank you for the opportunity of speaking to you, gentlemen.

Mr. DANIELS. On behalf of the committee, Mr. Bloom, I want to express our thanks for the sentiments which you have expressed here today.

Mr. BLOOM. Thank you.

Mr. DANIELS. Now our next witness will be Mr. Szymanski, of the Jersey City Board of Education.

Mr. Szymanski, you may proceed.

STATEMENT OF EDMUND SZYMANSKI, VICE PRESIDENT, BOARD OF EDUCATION OF JERSEY CITY, N.J.

Mr. SZYMANSKI. I want to apologize also because of the shortness of time, gentlemen. I have a prepared text here which I prepared regarding my viewpoint as a layman, as a businessman, in Jersey City, and also as a vice president of our local board of education.

There is one thing I do want to add, which is not in this text, and that is the fact that some 30 years ago the city fathers at that time saw this situation developing.

Lo and behold, they saw fit to organize one of our local schools, which is the A. Harry Moore School, named after our only three-time Governor of New Jersey, for this type of work to bring the children back to civilization and to a good civic life.

We have at the present time around 300 children attending this school. We draw on the entire county. It is all financed by the city of Jersey City through the board of education.

At this time, if it is all possible, I mentioned to Congressman Daniels some time ago, I would love to have the committee take a tour of this school and see what Jersey City has done.

Furthermore, at the Jersey City College across the street from this institution we have two classes now under the direction of Dr. Gilligan, who are following this type of vocation and they are being trained to take care of the physically handicapped, both mental and physical children, and adults, that may be in Jersey City and in the vicinity.

Other than that, gentlemen, I don't have much to say.

I believe our president was before you yesterday. He outlined his points of view and I think Miss Thompson is going to speak here today, if I am not mistaken.

Mr. DANIELS. She appeared this morning.

Mr. SZYMANSKI. She is our principal down there. I think through her, being that she is one of the professionals or the educators of this institution, she probably outlined that end of it.

Also, in Jersey City we have what we call a special service branch under the direction of Mr. Vincent O'Shea, who takes in the juvenile delinquents as we call them.

We do have plenty of those problems in Jersey City and I think a lot of it is attributed to a lot of the parents who are lacking in funds and in seeing that these children when they start out, who do not have the proper IQ, get the proper education.

I just returned from the Atlantic City AASA convention. I had the honor of listening to Mr. Eric Johnston, who was pinch-hitting for Senator Symington Tuesday night, outline the fact that the Federal Government only donates 4 percent of the total cost of education throughout the entire country. The city bears more than 50 percent, the State about 40 percent, and the balance, which is only 4 percent, is donated by the Federal Government.

I think it is about time that we did have some remuneration from the Federal Government to help offset our expenses here and keep our tax rates down.

Thank you, gentlemen.

Mr. DANIELS. Are there any questions of the gentleman?

Mr. QUIE. I wondered how he was going to keep his tax rate down by getting the money from the Federal Government.

Mr. SZYMANSKI. It will certainly keep our cost down as far as our taxpayers go, if we do get some funds to offset some of the special courses.

Mr. QUIE. We will be returning to Jersey City the same tax money it contributes.

Mr. DANIELS. Without objection, the text of Mr. Szymanski's statement will be incorporated in the record following your oral testimony.

Mr. SZYMANSKI. Thank you for allowing me to appear.

(The statement referred to follows:)

STATEMENT OF EDMUND SZYMANSKI, VICE PRESIDENT, BOARD OF EDUCATION,
JERSEY CITY, N.J.

I appear today before your honorable committee in a dual capacity—first, as a citizen and businessman actively interested in any measures or procedures that will benefit his community and the Nation, and, second, as vice president of the Board of Education of Jersey City. In the latter capacity, I am particularly interested in matters pertaining to the education and welfare of the children of today who, as citizens of tomorrow, will have entrusted to them the destiny of the United States.

For generations, the education of our children has been a major concern of the leaders of our Nation. This has long been a proud and important part of the American heritage and has served as an inspiration and guide to the other nations of the world.

Gradually, the scope of American education was expanded to include facilities for the education and training of children needing special consideration and help and for the preparation of teachers for work in the important field of special education. It came to be recognized that society has an obligation not alone to the so-called normal child, but also to the child who unfortunately possesses disabilities of one type or another and who, therefore, needs specialized educational facilities and assistance by a corps of teachers particularly trained in the field of the existing disability.

The provisions of educational opportunities for children who need special help and training is a highly commendable effort from a moral and humanitarian standpoint, but it also represents a most realistic and practical approach. The Nation is, indeed, benefited and strengthened whenever steps are taken toward developing to the maximum the individual capabilities of each of its citizens.

There is another practical consideration that enters into an appraisal of the importance of special education. Some of the causes of juvenile delinquency are firmly rooted in the sense of failure that results when a child is faced each day with school tasks that are beyond his ability to perform. This sense of failure frequently leads to a feeling of hopeless frustration which, I need not stress, is highly destructive from a psychological standpoint. The next step, beyond failure and frustration, is very often a feeling of bitterness and resentment, leading easily to the development of antisocial attitudes and the commission of antisocial acts.

The answer to this challenge lies in the provision of special education programs of such richness and scope that the child will be able to achieve success in his school tasks. From this success will inevitably arise feelings of accomplishment and success and a sense of really belonging.

Surely, these beneficial effects, plus the education and training that he receives from a special program geared to his individual limitations and needs, will make him a more effective citizen of our democracy at a time when such citizenship is particularly needed in view of the disturbed situations existing throughout the world.

One may be sure that many States and communities which recognize the compelling need for special instruction and training for both children and adults who are in need of it are, nevertheless, prevented by financial considerations from establishing appropriate programs. They recognize that it is in the interest of society and of the Nation that assistance be rendered to handicapped individuals in the fields of special education and rehabilitation, but because of lack of funds they are unable to provide such assistance.

The Committee on Education and Labor of the United States House of Representatives is greatly to be applauded for its recognition of the problems that exist in the fields of special education and rehabilitation and for its intensive study of the role that the Federal Government can take in assisting local communities toward a solution of those problems.

As regards H.R. 3465 (independent living bill) and House Joint Resolution 494 (a bill to provide for training of teachers of the deaf and speech pathologists and audiologists), as well as H.R. 1119 (to provide evaluation of rehabilitation potentials and rehabilitation services to handicapped individuals) and House Joint Resolution 316 (to encourage the expansion of teaching in the fields of speech and hearing), it is my opinion that favorable action would greatly assist the communities in certain aspects of special education and rehabilitation.

Mr. DANIELS. Our next witness is R. H. McDonough, director of the Division of State Library, Archives, and History, New Jersey State Department of Education.

STATEMENT OF ROGER H. McDONOUGH, DIRECTOR, NEW JERSEY STATE LIBRARY; MEMBER, EXECUTIVE BOARD, AMERICAN LIBRARY ASSOCIATION

Mr. McDONOUGH. My name is Roger McDonough. I am director of the Division of the State Library, Archives, and History, of the New Jersey State Department of Education.

I am here today in my capacity as a member of the executive board of the American Library Association, a nonprofit, professional association of more than 23,000 members, consisting of librarians, trustees, and friends of libraries interested in the development, extension, and improvement of libraries as essential factors in the educational, social, and cultural aspects of society.

The American Library Association is keenly interested in the subcommittee's study of educational services to the gifted child.

Our deep concern in this matter is reflected in the number of articles on the subject to be found in library periodicals.

It is also evidenced in the increasing attention school administrators and librarians are giving to the problem of making certain that children in elementary and high school are surrounded with books that can enrich their regular courses and hold open to the gifted and intellectually curious child the means to explore new fields for himself.

A recent issue of the official publication of our organization, the ALA Bulletin—American Library Association, ALA Bulletin, February 1958, volume 52, No. 2—was devoted to the subject, "The School Library and the Gifted Child."

I would like to quote from the foreward to this special issue, which was written by Mrs. Lillian L. Batchelor, supervisor of secondary school libraries for the Philadelphia Board of Education.

Mrs. Batchelor is past president of the American Association of School Librarians, a division of American Library Association:

No problem is of greater national concern today than the education of the gifted. Recent events have served to focus wide attention on the subject, although leading educators have long stressed its importance to all of us. Now, for the first time in many years, the identification, development, and utilization of our greatest national resource, human talent, is being recognized as a priority item in education.

The library is in a strategic position to enrich the curriculum and to render unique service to the school. Good library facilities are generally considered indispensable to the creative teacher working with bright children * * *.

It is hoped the material in this issue will prompt more librarians to plan for their gifted students, for no work is more needed—or more satisfying. Books are truly "the gunpowder of the mind," and librarians should know how to use them to fire the imagination and ambition of bright young people.

In Essex County, N.J., the local superintendents of schools and the librarians of the public and school libraries, have formed a study group to survey existing library facilities for the purpose of determining how their services to the gifted and exceptional child may be improved.

This action stems from doubts about the adequacy of present facilities. If Essex County, with its splendid Newark library and many fine suburban public and high school libraries, is not able to meet all the demands made upon it at the present time, one wonders what the rest of the State is able to do with much less in the way of library resources to draw upon.

I have said that librarians are deeply concerned about this matter, but I would like to emphasize that our concern and interest is not of recent origin.

Providing good books to every American who wants to read them for his self-education and development is at the very root and core of our American library philosophy.

Benjamin Franklin founded the first American library in 1731 in order that everyone in Philadelphia would have the opportunity for self-education.

Over the years, countless numbers of Americans have been assisted by librarians who, as educators in the best sense of that term, have led willing and avid readers along intellectual paths of their own choosing, allowing each to reach his respective goal as quickly as his mental abilities would allow.

The fact that librarians in former years did not call their gifted readers by that term does not alter the fact that libraries have been giving special attention to these people for a very long time.

To turn now to the subject of library service to the handicapped, I think you will be interested to know that one of the very active groups within the American Library Association is the Association of Hospital and Institution Libraries.

This organization represents libraries which serve patients, medical, nursing, and other professional staffs in hospitals and inmates or residents and professional staffs in institutions.

These libraries are an integral part of the care program provided by hospitals and institutions.

It is interesting to note that the AHIL has submitted to the National Institute of Mental Health for its consideration a proposal in the field of bibliotherapy entitled "Reading: Its Role in Rehabilitating the Mental Ill."

If funds are granted, a group of experts will meet at the Veterans' Administration hospital in Topeka, Kans., for an intensive work session covering current research, knowledge, and insight on the successful use of reading as a tool in the group treatment of the mentally ill.

It may be noted also that a number of publications useful in the field are available at American Library Association headquarters and include the following:

1. "Hospital Libraries: Objectives and Standards, 1953."
2. "Selected Readings in Hospital and Institution Libraries, 1959."
3. "Reading Aids for the Handicapped, 1959."
4. "New Horizons: Readable Books About the Physically Handicapped, 1951-56."

I have a copy of "Reading Aids for the Handicapped, 1959," with me this afternoon and I am happy to leave it with the committee.

Mr. McDONOUGH. If the committee will pardon another reference to New Jersey, I would like to invite your attention to the State library's work with the department of institutions and agencies.

In an effort to assist this department in improving its services to penal, correctional, and mental institutions, we developed some years ago a matching book plan, whereby our bureau of public and school library services gives special book service to the 21 State institutions.

In addition, the bureau offers consultative and advisory services to the educational directors of all institutions involved, conducts workshops, and, in general, cooperates on a continuing basis with officials of the department.

I have brought with me a pamphlet that describes this matching book plan service, together with a letter from Mr. Donald Goff, expressing the appreciation of the department for this cooperative venture in improving library services to State institutions.

I am sure that similar service is being given in many other States, but this one example will serve to indicate the library profession's interest in this subject.

All the public libraries in Hudson County have banded together to provide prison library service in county facilities here.

I could not conclude my remarks this afternoon without reminding the committee that the Library Service Act, while it was designed

primarily to assist rural libraries and was not specifically aimed at either the gifted or the handicapped, has been a new source of strength in serving both.

The act has made possible for the first time rural library service to millions of Americans. In New Jersey we have devoted a large part of the fund available to setting up a three-county regional library in the southern rural part of our State.

To mention just a couple quick examples of how this service has helped handicapped people, one retarded boy who suffered from a brain injury has used the bookmobile over a continuing period. He was reading at a very low level; he is only at a 7-year level instead of 12, but the reading of good books has helped him considerably.

In another instance a woman housebound with arthritis receives biweekly groups of books that are especially selected for her by the bookmobile librarians.

In another instance, a gifted youngster whose teacher felt he could be helped by a good plan of reading, is now changed from reading well below his level of ability through systematic work with the librarian to a point where he is now on his way to reaching his full intellectual potential.

In conclusion I would like to say that the American Library Association heartily supports the study program undertaken by the subcommittee.

We trust that you will not lose sight of the rural libraries, the role the rural libraries can play in assisting both the gifted and the handicapped throughout the Nation.

The association stands ready to assist the committee in any way it can in pursuit of your worthy objectives.

Mr. Chairman and members of the subcommittee, I am deeply grateful for the opportunity to appear here this afternoon.

Mr. DANIELS. Does the State library furnish any services for our blind or are you entirely dependent on the Library of Congress?

Mr. McDONOUGH. We are dependent on the Library of Congress through the Philadelphia Library.

Mr. DANIELS. Does the State of New Jersey make any contribution for the printing of braille books for the blind?

Mr. McDONOUGH. Unless it is done through the commission of the blind in Newark, I could not say. I do not know, Mr. Daniels, that we are not contributing to the Philadelphia free library for the regional library service it provides to the New Jersey blind readers.

Mr. DANIELS. Are there any questions?

I gather that there is only repository for the Library of Congress for braille books in New Jersey is in Philadelphia?

Mr. McDONOUGH. Yes, it is on a regional basis.

Mr. QUIE. Do the machines come from Philadelphia or do you handle that?

Mr. McDONOUGH. This is worked out between the Philadelphia free public library and the State commission for the blind.

Mr. DANIELS. Thank you very much for your testimony, Mr. McDonough.

Mr. McDONOUGH. Thank you.

Mr. DANIELS. I would like to acknowledge the presence in the audience of Mr. William J. Roehrenbeck, director of the Jersey City Library.

Mr. DANIELS. Our next witness will be Mr. Paul R. Reed, chairman of the Legislative Committee, Pennsylvania Association for Retarded Children.

STATEMENT OF PAUL R. REED, SECOND VICE PRESIDENT, PENNSYLVANIA ASSOCIATION FOR RETARDED CHILDREN, INC.

Mr. REED. Mr. Chairman, I am deeply appreciative of the opportunity to appear for my organization, the Pennsylvania Association for Retarded Children, and to present testimony to this committee on special education and rehabilitation.

These issues are central to the purpose of our association. We appreciate the work which your committee has done in the past toward the extension of these services and look to you for a continuation of the interest and energy which has brought to Pennsylvania the beginnings of sorely needed programs and services.

Our association is made up of 42 chapters throughout the State comprising some 5,500 members. I know that you and the members of this committee are aware that the principle reason for the formation of our association some 10 years ago was the lack of those very services to which you are now addressing yourselves.

I will not take the time to outline in detail the present level of special education and rehabilitation programs in this State; we are submitting an attachment to this statement which describes in some detail the diffusion and scattering of services among five departments of the Commonwealth and which makes recommendations for a 10-year plan calling for the rationalization and phased achievement of seriously needed services.

In addition, we are submitting some brief tabulations showing the number of mentally retarded individuals now served in special education classes, indicating, also, the percentage estimated to be in need of these services but not now receiving them. I will want to refer to these tabulations somewhat later in these brief remarks.

It is our contention that the services to the mental retardate should comprise a logical continuum of services starting with the extremely important early diagnoses and evaluation and proceeding from this to counseling with parents on the future of the child, to services in the home to be provided by visiting teachers and by public health nurses, to health programs designed to bring to the optimum the overall health of the child; the provision of preschool programs, classes for school-age mental retardates, with emphasis in later years on pre-vocational preparation and vocational training.

In this continuum of services there must also be provision for occupational training, sheltered employment, and recreational facilities geared to the need of the retardate.

The institution or residence home, given the services which are needed in the local community, then becomes a specific instrument with specific purposes for specific individuals whose needs cannot be met in the community or who need the particular and especial services of the residence home at one or another period in their lives.

In no part of the State are services provided on anything approaching so comprehensive or logical a basis. Fully 23 percent of the mental retardates who might profit by training in classes for the "trainable" child are not now in such classes.

Of the educable group (those, generally speaking, with intelligence quotients above 50 and below 75) 29 percent in the elementary age group are not receiving specialized education, and 52 percent in the secondary age group are not receiving specialized education.

As is pointed out in the attached statement recently presented by our association to the Governor's Committee on Handicapped Children, headquarters staff in the department of public instruction is inadequate in number to give to the school districts now providing these classes the kind of leadership and assistance required and is for the same reason completely unable to do the job of taking the initiative and leadership in developing needed classes where they do not now exist.

The bureau of vocational rehabilitation gave services in the past fiscal year to 811 mental retardates, of whom 247 were placed in "satisfactory employment" at an average cost of \$346.79 per case, placed. During the current fiscal year, 521 mental retardates have been served to date by the bureau in 26 sheltered workshops as against 24 for the previous year. No figures are available on the actual numbers trained by the bureau of vocational rehabilitation in sheltered workshops.

I would like to say that we have no accurate estimate of the numbers requiring educational and training services in the schools nor the numbers who might profit from the training programs of the bureau of vocational rehabilitation in sheltered workshops.

We do know from direct experience in a number of areas of the inadequacies of the census taken by the local school districts, and, so far as we know, no attempt has been made to gather information on the numbers who might profit from a well-established program of case finding, family counseling, and evaluation leading toward programs of training, placement, on-the-job counseling, and sheltered employment.

One new aspect of the program in Pennsylvania warrants your consideration; that is the program recently undertaken by the department of public welfare to provide in sheltered workshops long-term sheltered employment for mental retardates no longer served by the public school systems and declared ineligible for service by the bureau of vocational rehabilitation.

In this description I will be able to touch only briefly on the role of the State schools and hospitals for the mentally retarded. Of the 10,000 now in residence, many need not have been placed there in years past had the range of services described above been available even in part.

In recent years the proportion of the severely retarded entering the institutions has increased sharply as local services (primarily classes for trainable individuals, and sheltered workshops) have become available. The point I wish to make in relation to the institutions is that there has been a lamentable lack of relationship between the existing and developing services of special education and rehabilitation and the institutions.

Mr. Chairman, I would like to turn now to some specific suggestions for the consideration of your committee.

1. As a result of programs and projects established through appropriations under the Department of Health, Education, and Welfare, experience is developing on the structure and specific provision of

services. I would urge that a major recommendation of this committee be that the appropriate agencies of the Department of Health, Education, and Welfare provide active encouragement and assistance to the State of Pennsylvania in the planning and establishment of a logical structure of services. This would include assistance in the establishment of needed diagnostic and evaluation clinics (over and above those now operating) in the extension of maternal and child health services, in the inclusion in all services of adequate reporting and research activities.

2. A second suggestion I would like to make is that none of the needed services can be provided adequately without an absolute increase in trained personnel in all the agencies giving service to the mentally retarded.

Counseling and stimulation are needed in providing sufficient headquarters staff for inservice training and means must be found for sharply increasing the number of teachers trained in the field of special education.

As services to the mental retardate provided by the bureau of rehabilitation increase, the need for standards of training for those working in this field becomes more apparent. I would urge that the Office of Vocational Rehabilitation take positive initiative in extending its services in the upgrading of personnel which is required.

The values which inhere to the retardate, to his family, and to the community at large from the provision of effective training require more for their achievement than space and equipment; they can only be made truly available through skills which can be taught to qualified personnel. Still another area in which there is a need for training of personnel is in the counseling services which give meaning to the results of a diagnosis. Effective and meaningful interpretation to parents can serve to mobilize the strength of parents on the side of those helping to provide special services to the mental retardate.

I have emphasized the importance of a rational plan, the importance of a coordination of services. One of the most pressing of these needs is that of cooperative work between the bureau of vocational rehabilitation and the training programs in the secondary school programs for the mentally retarded. Here, too, I believe that the appropriate agencies within HEW can and must give effective leadership.

If the purpose of these special services is to make it possible for the retardate to participate, wherever possible, in the life of his community to the full, then the whole structure can fall if adequate community living and recreational facilities are not provided. It is in this area that the least progress has been made, and I would also urge that your committee consider methods of providing to the States guidance and leadership in the development of programs.

I would like to conclude my remarks with a statement of full support for H.R. 3465, the independent living bill, which you, Mr. Elliott, have introduced in the House of Representatives.

Those of us who have been faced for many years with the direct responsibility for the care of a severely handicapped child know in our bones what the kind of help proposed in this bill would have meant and can now mean. We believe that the limited services toward these ends which we have been forced to initiate and support in recent years, have demonstrated the results which can be achieved.

through the application of skill and understanding to the training of the severely mentally retarded.

We know, too, that the sheltered workshops in Pennsylvania reach only a small percentage of those who could profit from the training and sheltered employment which would be provided by the increased numbers of sheltered workshops envisaged in this bill.

Mr. Chairman, in conclusion I wish to take note of one statement in the finding of fact and declaration in H.R. 3465, that which calls attention to the fact that the provision of independent living rehabilitation services would contribute greatly to the dignity and self-respect of the severely handicapped person. It is toward this deeply human objective that we in the Pennsylvania Association for Retarded Children have striven, and it is with deep appreciation that I note that this, too, is your motivation and that of your committee.

(The material referred to follows:)

EXHIBIT 1

STATEMENT ON PROGRAM NEEDS OF THE MENTALLY RETARDED

I. CURRENT AND FUTURE NEEDS OF THE MENTALLY RETARDED IN PENNSYLVANIA

An inclusive program for the mentally retarded would include:

1. Early identification.
2. Diagnosis and evaluation by a professional team; skilled counseling to be available when needed.
3. Adequate care and treatment in a coordinated program of Commonwealth and local services.
4. Appropriate education, either at school or at home.
5. Appropriate recreational facilities.
6. Vocational guidance and training.
7. Education of the public for acceptance and support.
8. Programs of research in causation and in the provision of services.
9. Modern training programs for professional workers.

II. QUALITATIVE AND QUANTITATIVE MEETING OF THESE NEEDS BY THE COMMONWEALTH AND BY LOCAL SERVICES

The Commonwealth now provides services to the mentally retarded through the departments of public welfare, health, public instruction, labor and industry (bureau of vocational rehabilitation), and justice. None of these departments, to our knowledge, has developed an overall, long-range, realistic plan for the coordination, improvement, and expansion of its services to the mentally retarded, nor has the Commonwealth developed a program which would rationalize and coordinate the services provided by these departments. While there has been in recent years an increase in the provision of services by the various departments, it is our position that real progress in work toward a truly effective program awaits the preparation of a comprehensive 10-year plan which will serve as a guide in legislation and administrative work toward meeting present and expected needs of the mentally retarded.

Our association recognizes that advances in the organization and provision of services to all individuals requiring specialized skills will result inevitably in improvement in the services available to the mentally retarded. We welcome and support the activities of the Commonwealth toward these ends. Nevertheless we maintain that the needs of the mentally retarded are so extensive and the services to meet them so scattered that a plan specifically concerned with these needs and the rationalization of services must be developed.

Department of public welfare

Over 3,000 mental retardates are on waiting lists for admission to the Commonwealth schools and hospitals for the mentally retarded. There should be no waiting list for services and care for which the Commonwealth has an obligation. The department has been hampered in the development of its program by staff shortages and limited financial appropriations and by the very extent of

the problems resulting from this long period of neglect. Phased construction of additional institution is now underway, but a serious lag still exists in the employment of headquarters staff charged with program planning and staff recruitment and training. Programs within the institutions are also limited by staff shortages of long standing and by the absence of established and comprehensive statements of program and treatment objectives which were impossible of achievement given lack of staff and lack of money. Relationships with communities and community services, while improving, are not yet the subject of well-coordinated planning and development within the department, although moves in this direction are now in progress. Research programs in the institutions are not coordinated nor sufficient in number and variety, nor is adequate headquarters staff provided to give leadership and continuity to research programs.

The department has taken an important step forward in the new legislation for which it secured passage, which provides funds for the support of local work-oriented programs for older age retardates. Training programs and internships for professionals are expanding but need to be tied into the comprehensive departmental plan we believe is required.

Department of public instruction

This department administers and supports classes providing training and education for mental retardates who are educable and for those who are trainable. In many areas classes are not provided for all retardates who could make use of them. The application of current regulations permits the deferment and excusal of retardates below the age of 8 and over 16, and insufficient attention and leadership has been given to the problem of developing appropriate curriculums for these age groups. Moreover, present legislation permits and supports training of the cerebral palsied, blind, and deaf in "preschool" age groups, but this financial support is not now available to the mentally retarded.

Headquarters staff in the Department is insufficient to give proper leadership and guidance to the special education classes conducted by the school districts, nor has the Department, so far as is known, taken appropriate steps to provide leadership in developing programs in special education to be undertaken in the near future in the state (teacher) colleges.

So far as is known, no long-term plan for the development of headquarters services to the districts or to the teacher-training institutions exists.

Department of health

The programs of services to the mentally retarded provided by the department are increasing and improving. We believe that a review of the variety of services provided by public health nurses, maternal and child health clinics, and diagnostic and treatment clinics, with a view toward arriving at a comprehensive program for the department, and in relation to those of the other departments, is necessary.

Department of labor and industry (bureau of vocational rehabilitation)

The bureau has been active in support, evaluation, and training of limited numbers of retardates in sheltered workshop facilities in many parts of the State. The development of this program, however, has been spotty, and there is a serious need for staff programs of training for counselors responsible for this program.

Greater emphasis on the organization of program and the recruiting and development of staff in the Johnstown Rehabilitation Center in order to provide increased training programs for the retardate would seem to be indicated.

More intensive relationships between the BVR and the school districts in relation to coordinated training programs for the mentally retarded is necessary.

Department of justice

A critical review needs to be made of the programs provided by the justice department for the so-called defective delinquent.

Local services

Foremost among the needs on the local level is that of skilled diagnosis and evaluation which includes counseling for the parents and, where required for the

retardate as well. Nowhere in the State is this service offered to the extent required. Few, if any, communities provide the wide range of other services which would permit for each the full development of the capacities of the retarded. These would include home-training programs by public health nurses and visiting teachers, preschool training programs, adequately staffed and programed public school classes, recreation programs for all age levels, vocational training and sheltered employment facilities, and local residence shelters. While improved local planning is needed everywhere, we believe that the magnitude of the problem and the variety of skills required are such that the Commonwealth must assume the leadership both in planning for and in the provision of services which by their very nature cannot be developed or supported by the local communities.

III. CONCLUSIONS

We believe that the Commonwealth must take effective initiative in establishing a comprehensive long-term program of services to the mentally retarded. Such a plan, by virtue of its inclusiveness, would permit and require the development and support of related local programs of service.

It might also be added that such a plan, spotlighting as it would needed Commonwealth and local services, would permit more effective planning for the request and use of Federal funds.

It is our position that defined and comprehensive and appropriately staffed and coordinated programs for the mentally retarded are needed within the broad framework of services to all handicapped individuals, and without discrimination by virtue of diagnosis of mental retardation. We have reached no conclusion on the structure which will best provide these services and are aware of the advantages and disadvantages which might inhere in the establishment of administrative or legislative commissions to rationalize or administer these services. While we are eager that the greatest amount of progress be accomplished, we want to be certain that the proposals made are most likely to be accepted by the administration and the legislature. We welcome the opportunity to participate with the Governor's Committee on Handicapped Children in the search for the most effective means for meeting the needs of the mentally retarded.

EXHIBIT 2

Special pupil services, full-time program, school districts of Pennsylvania

Handicap	Number of classes	Number of students	Total number of children with handicap	Percent of total not receiving instruction
Mentally retarded, educable:				
Elementary.....	1,212	19,892	28,220	29
Secondary.....	398	8,722	18,190	52
Mentally retarded, trainable.....	201	2,535	3,303	23
Physically handicapped.....	159	2,368	2,827	16
Deaf or hard of hearing.....	26	367	852	58
Blind or partially sighted.....	19	237	596	60

Source: From "The Report of the Citizens of Pennsylvania for the Golden Anniversary White House Conference on Children and Youth, Nov. 15, 1959," prepared for Governor's Coordinating Committee for the 1960 White House Conference on Children and Youth.

EXHIBIT 3

Number of mental retardates served by PARC sheltered workshops

County chapter	Under 5	6 to 10	11 to 15	16 to 20	Over 20	Present capacity ¹	Anticipated capacity ²
Blair.....	X.....					20	20
Bucks.....			X.....			15	30
Butler.....				X.....		35-40	80
Centre.....		X.....				10-12	20-30
Cumberland.....					X.....	25	
Delaware.....				X.....		20	60
Erie.....					X.....	20	
Franklin.....					X.....	30-35	80
Lackawanna.....			X.....			15	45
Lawrence.....				X.....		35	50
Lehigh.....			X.....			15	50
Luzerne.....				X.....		50	
Mercer.....				X.....		20	
Montgomery.....					X.....	40-50	80
Philadelphia.....					X.....	40	50
Venango.....	X.....					15	20
Washington.....		X.....					

¹ With present facilities.² With subsidiary help and in some cases extension of physical plant under present administrative setup

Mr. DANIELS. At this time we will declare a 2-minute recess in order to permit the photographers to take a picture because it is a violation of the committee rules to take pictures while the committee is in session.

(A short recess was taken.)

Mr. DANIELS. Our next witness will be Mr. John Charlton, department of public instruction, Dover, Del.

STATEMENT OF JOHN CHARLTON, DEPARTMENT OF PUBLIC INSTRUCTION, DOVER, DEL.

Mr. CHARLTON. Mr. Chairman and members of the subcommittee, it is an honor and a pleasure to have this opportunity and to have been invited to give testimony on the most urgent need of Delaware in the field of special education and to make specific suggestions as to how the Federal Government might aid the States and local communities in attempting a solution to some of these pressing problems.

I bring you first the greetings and best wishes of His Excellency, J. Caleb Boggs, Governor of the State of Delaware, the first State, Mr. Dusen, president of the board of education, and Mr. Millard, Jr., State superintendent of public instruction.

Delaware was the first State to ratify the Federal Constitution and since that time has taken great pride in being first in all of its endeavors for the benefit of citizens of our Nation.

This is the 10th year of our consolidated integrated and coordinated program of services in the division of child development and guidance.

What has formerly been known as the division of special education and mental hygiene was changed to child development and the guidance service were added on July 1, 1949.

Delaware has been a pioneer and leader, beginning with the ground work of Dr. Robert.

Public popular support has increased to a point where there is tremendous enthusiasm for the assumption of the public education

of the entire program for all exceptional children from the trainable to the gifted.

Because of our rapid phenomenal growth we have tried to consolidate our gain and approach further expansion with all evidence available for objective and subjective evaluation.

In looking ahead we would approach each facet cautiously to improve our services with knowledge and information gained through pilot programs and intensive research in the State and in the Nation.

The Office of Education recently selected Delaware, New York, and Connecticut in a study as States having an emerging pattern of pupil personnel services.

Delaware is again taking the leadership role in the development of the trend throughout the United States in combining specialized educational programs under the administration of one division.

The coordinated and integrated services are rapidly becoming known as an integral part of the total pupil personnel service.

This type of program makes it more possible to serve each individual child as a whole child or a total personality in a complete

This type of program makes it more possible to serve each individual child as a whole child or a total personality in a complete educational setting.

Our primary goal is to assist the local schools in State institutions with specialized educational services and personnel which will make it possible in Delaware to provide equal opportunities for every child regardless of his residence and in accordance with his interests, aptitudes, abilities, or disabilities.

The optimum development of each child is our goal.

There has been a great deal of misunderstanding about the word exceptional. However, we use the nationally adopted generic term to refer to those who deviate from what is supposed to be the average in physical, mental, emotional, or social characteristics to such an extent that they require special educational services in order to develop to their maximum capacity.

An exceptional child is, first of all, a child. But due to his exceptionality he needs special assistance to compensate for, or to make the best use of, his abilities or his disabilities.

Without this special assistance approximately 10 to 12 percent of our general and school population cannot ever receive his birthright as an American citizen, the right to learn consistent with his capacity to learn in order to become economically useful and socially adjusted.

With Delaware's program, I would estimate that we are meeting the basic needs of approximately half of our exceptional children.

During the last 10 years we made our greatest progress in our instructional program through the unit allocation law which makes it possible for any local school or district to receive a teacher's salary in accordance with the State schedule plus \$750 for each unit or major fraction thereof of the unit.

The unit means 25 in the elementary school; 20 in the secondary school, and for exceptional children as follows:

The educable retarded, 15;

Trainable retarded, six;

Socially and emotionally maladjusted, 15;

Partially sighted, 10;

Blind, eight.

Partially deaf or hard of hearing, 8, and orthopedic, 10.

Our State legislature has been very cooperative in providing funds for teachers. However, each succeeding year it becomes increasingly more difficult to secure funds for administration, supervisory and auxiliary services such as psychological, speech and hearing, education and social work, guidance workers, all of whom must be paid for out of the special appropriation or be taken from the unit allocation by increasing class sizes.

We have very good cooperation and coordination of services provided by State agencies. We provide consultation and supervisory services in all State institutions for school age children.

There is some overlapping of services provided by the crippled children's services and by the rehabilitation division.

However, I think I can say because of our close relationship and coordination of services that there is no duplication of services to individuals.

We believe we have one of the finest public school programs for exceptional children in America.

Now the vocational rehabilitation program—I cannot speak officially for the Delaware vocational rehabilitation program and think our State director, Mr. John G. King, has been here.

However, I can say that we have a fine relationship in coordinating our respective services. I am sure that Mr. King is quite proud of the excellent record that Delaware has made and the national recognition of having been rated at the top for many years.

We have some problems, but I am confident that we can continue to solve them for the best interest of those concerned.

Now Delaware's position in population growth and finance and taxes, our little State consists of three counties; some say at high tide and only two at low tide. All of us think it is a very good State in which to live. Our population in 1950 was 230,000 and it has been predicted that by 1960 census it will reveal some 470,000 or more with no signs of slackening.

Per capita personal income in Delaware amounted to \$2,760 with Connecticut exceeding Delaware by \$47.

In contrast in the lowest State the per capita income was \$1,053, and the United States averaged \$2,057.

With almost any measure of wealth Delaware ranks in the top half of the Nation and usually in the top 10 or 20 percent. This was taken, not as a direct quote, but from a study, the Delaware School Study Council, on Physical Survey Bulletin No. 1, January 1960.

Delaware pays approximately 85 percent of all school costs at the State level. Over 50 percent of our schools receive 100 percent State support from the State level. All school construction is financed 60 percent State and 40 percent local.

We have one of the highest State-supported salary schedules in the country. Some of our schools in New Castle County and Wilmington area supplement the State salary up to an additional \$2,000 over the State schedule, and even with the schedule of \$3,200 to \$5,100 for the baccalaureate, with \$3,600 to \$5,900 for the master, masters

plus \$3,400 to \$6,390, of the doctorate \$4,400 to \$6,700, we still cannot compete with many of our neighbors.

It has been said that Delaware sends the Federal Government almost 10 times as much as it uses for its own State Government. It has also been said that Delaware sends \$6 to Washington for each \$1 it gets back in Federal funds.

I firmly believe that Delaware is financially able to provide for our educational services and our citizens are willing and able to pay for these services if we as leaders and educators will let our people know what needs are and see that these funds are properly administered and accounted for.

Now, the need for help from the Federal Government. My preceding statements do not mean that we do not need help from the Federal Government. During the last few days in our Philadelphia workshop at our hearing many constructive recommendations were made. I wish to make the following suggestions:

1. That the Federal Government study the possibility of evaluating, assessing, consolidating, and reorganizing their present appropriations and organizational structure for the program of special education and rehabilitation services.

2. That the Federal Government consider ways and means of assisting States for the following:

Research: Treatment centers, both physical and mental. Program of prevention, early identification, diagnosis, treatment and education, publications in literature, clearinghouse for the Nation's practices, and methods and techniques.

Area national workshops with consultants and specialists sharing the best in America.

Well-defined written statements requiring interagency articulation, coordination, cooperation, and integration of services.

Funds for training of specialized teachers of exceptional children, psychologists, speech and hearing therapists, physical therapies, education and social workers, and other personnel.

Plans for teamwork and sharing by interdisciplinary cooperation and cooperation by various media and professional know-how.

Pilot studies to demonstrate the need and value taken over by the States to carry on later.

Vocational training for slow learners and the retarded should be provided.

Delaware needs most now—our greatest need in Delaware at this time is for more guidance counselors, speech and hearing therapists, physical therapists, dental hygienists.

We need help especially in our two lower counties. The Government should consider, I believe, all of the assistance from the Federal Government should be on the basis to initiate, to encourage, to promote, and to extend services for exceptional children and for rehabilitation, but not forever subsidizing them.

I would suggest that financial support be given on a hundred-to-zero basis over a 5-year period. With a hundred percent the first year, 80 percent the second, 60 the third, 40 the fourth, 20 the fifth, and the sixth year all of the States should pay their own way, unless it could not afford the program, and then our children must be our most important consideration and receive these valuable services.

They should not suffer, but have a life worth living in accordance with God's plan for all mankind.

I wish to commend the committee for their planning. If no Federal funds are granted, the emphasis which has been placed on the problem, to share ideas in the workshops and these deliberations in these hearings, will have far-reaching effects on the actions of our citizens throughout America far beyond any of our expectation for our exceptional children and adults in our own States.

Thank you very much.

I have two printed bulletins and some mimeograph material which I would like to leave for the committee, if they see fit.

Mr. DANIELS. That will be filed for the record.

Mr. CHARLTON. I have no copy of this. I would like permission to type it and show the boss what I said.

Mr. DANIELS. I might suggest this, sir, if you can have it typed and mailed to the committee within the next 10 days.

Mr. CHARLTON. I will appreciate that.

Mr. DANIELS. Are there any questions?

Mr. GLAIMO. I would like to commend the gentleman for a very fine and informative statement and one which I think is very helpful.

Thank you for your references, you have been rather kind to Connecticut.

Mr. QUIE. I also want to commend you for your statement. Between 1955 and 1957 you made quite a thorough study of the special educational needs in the State of Minnesota and we used the example of Delaware quite extensively not only in our deliberations, but also when we decided on the kind of program we passed in the 1957 session of legislature.

I can see that your presentation is consistent with what you have done in the past that we studied at that time.

Mr. CHARLTON. Thank you.

Mr. DANIELS. I want to thank you for the fine work that has gone into the statement you have made.

Mr. CHARLTON. May I mention that we have an annual census of exceptional children where I get the names of every child in our public schools who is in need of our services.

We are still not meeting them, but at least we know where most of them are and who they are.

Thank you very much.

Dr. BARNARD. Mr. Chairman, I would like to request that at this place in the record the statement of the Reverend Carl Futchs, of the Lutheran Welfare Association of New Jersey, be entered.

Mr. DANIELS. Without objection, the statement of Dr. Futchs will be entered in the record at this point.

(The statement referred to follows:)

STATEMENT BY THE REVEREND CARL FUTCHS, EXECUTIVE SECRETARY, THE
LUTHERAN WELFARE ASSOCIATION OF NEW JERSEY

It is a privilege to be able to testify to this committee concerning the needs for preventative and rehabilitative care as seen by my staff.

NEEDS FOR TRAINED PERSONNEL

Invariably when the subject of welfare needs of people arises, the tremendous need for trained personnel is raised immediately. This is true of teachers trained in prevention and rehabilitation in all areas of need of the handicapped.

It is good to see this stressed in House Joint Resolution 494 with regard to the needs of the deaf. The lack of trained social caseworkers in all the areas of need is tragically evident. The wide use of untrained (high school and college graduates) personnel is extremely costly in delay, emotional upset, and detrimental even to the eventual helpfulness in solving the problem. This is true, also, in actual dollars and cents costs. A devoted and fully trained worker is capable of professional and accurate diagnosis of emotional need (which is usually the basic need even in physical handicap) in a much shorter period of time and with less upset to the person served than can the untrained. In my opinion, therefore, it is mandatory that recruitment efforts and scholarship helps must be provided in the areas of service covered by the study of this committee. Such action as that recently taken by the New York State legislature is deplorable and detrimental to good service. Lack of trained personnel to do the work that must be done makes such action necessary.

Prevention.—More study of causes and prevention or at least early diagnosis and treatment of all physical and emotional handicap is another essential. Too much time, money, and effort has been centered on help toward amelioration of conditions which result from these handicaps rather than in prevention. Recent excellent examples of the benefits of such study is the Salk vaccine and the study of the effect of too much oxygen upon the eyesight of babies born prematurely. Such studies would certainly be helpful in the areas of emotional need such as mental and emotional breakdown, delinquency, family deterioration, etc.

Here I would underscore the need (1) for early detection of these disorders by more research, more clinics, and more school psychologists; (2) for community resources for rehabilitation of ex-mental patients, more social workers are needed to handle individual case services and to do educational and liaison work with other agencies, organizations, and industry. Outpatient clinics to serve those who do not need hospitalization and those who have been discharged from hospitals; (3) psychiatric wards or wings attached to general hospitals would serve to facilitate services to those who need them.

1. Stimulation through publicity and financial help in the development of home care and homemaker services and other such helping prevention services will do much to sustain persons of all ages and conditions in situations where minimal help is required. For instance, the matter of proper food intake of older people will do much to prevent senility and dependence upon medical and mental hospital services. This is true of alcoholism also.

2. Rehabilitation of handicapped persons must be realistic or it can be detrimental instead of helpful. To train a deaf mute in the use of an IBM machine when sewing on a piecework basis is the only work available can be a waste of time of the teacher and pupil as well as being an emotional upset to the pupil.

3. Legislation: I find that in some respects the wide variance in the laws and practices of various States provide hardship to those they were meant to serve. Residence requirements from one State to another and even one county to another work handicap upon such persons as the aging and the child. In these times of such a mobile population it would seem that all States should have automatic and immediate reciprocal residence regulations based upon economic conditions within each community.

Better and more even legislation is necessary within and between States regarding the preservation of the rights of children, the rights of parents, and the termination of parental rights in cases of continued neglect and desertion of children.

The need for legislation change is true with regard to the needs of the mentally ill for treatment in clinics and in hospitalization. The law means to protect the person but it is based upon the ability of the person to recognize his own need when frequently the person is totally unable to know his need. The result is that often a tragedy to the person himself or to others takes place before treatment can be brought to the person.

These admittedly are ticklish problems and need careful analysis and action.

4. Education of the public: Publicity of findings and experience of others and how these experiments were developed would be helpful and stimulating in provoking thought and action. The recent article in Time magazine concerning the B & K enterprises of Oakland, Calif., which employed only those persons who had been mentally ill is thrilling, educational, and conducive to further action and understanding.

5. Administration: It is my opinion that the local community should, as far as possible, administer the programs in order to maintain local initiative and

stimulate local planning. Certain standards should be required by the Federal Government for the effectual operation. Local community, public, and private agencies and even private industry should be utilized to administer the program on a nonprofit basis. Wherever it is possible all such assistance should be removed from political influence and placed under the administration of personnel on the basis of experience, knowledge, and ability.

Thank you for the privilege of this appearance.

Mr. DANIELS. Our next witness is Dr. Leon Charney, educational consultant for the Association for Retarded Children.

Mr. Charney, you may proceed.

**STATEMENT OF DR. LEON CHARNEY, EDUCATIONAL CONSULTANT,
NATIONAL ASSOCIATION FOR RETARDED CHILDREN, NEW YORK,
N.Y.**

Dr. CHARNEY. Mr. Chairman, may I express my personal gratitude, and that of the National Association for Retarded Children, for this opportunity to participate in the functioning of a committee whose activities have been instrumental in focusing the attention of the Nation on the problems of exceptional children and adults.

It has been said that each generation has the responsibility for evaluation of both the goals toward which it strives and the extent of the progress made in the direction of those goals. In effect, the activities of this committee are part of such an evaluation.

Professionals and the general public are, as a result, reexamining the degree to which we have implemented the doctrine that the national welfare is enhanced in direct proportion to the ability of each individual to achieve to his maximum potential. In a very real sense, the history of the United States is reflected in the history of exceptional children and youth, and we can trace the broadening of our democratic ideals in the changing attitudes toward those who differ intellectually, physically, socially, or emotionally from the norm.

The National Association for Retarded Children, although specifically concerned with promoting the welfare of the mentally retarded, recognizes the strong ties of common interest and responsibility which unite our organization with those concerned with the deaf, blind, physically handicapped, and emotionally disturbed. Since disabilities tend to occur in multiplicities, it is hardly surprising that many of the outstanding issues and problems in the field of special education and rehabilitation cut across areas of specific interest and require a total united effort for their solution.

It is indeed startling to discover that the most reliable estimates reveal that not more than 1 in 4 of the children in the categories mentioned, are receiving the special educational services which they require if we are to implement the philosophy outlined above. A wide variation is noted from State to State in the degree to which public school services are available to such children.

In an attempt to present as broad a picture as possible of the current status of public school services to exceptional children, I should like to report on a number of States selected at random from the files of the National Association for Retarded Children.

In 1955 the State of California Interim Commission on the Education and Rehabilitation of Handicapped Children and Adults estimated that only one-third of the handicapped children in that State

were receiving any type of special education. In 1957 the commission reported:

While we have made some gains in these areas, the increase in our population, particularly among children of school age, has tended to outrun the gains.

The division of special education of the State of Iowa in 1956 estimated that there were 13,275 children with IQ's under 69 in that State. At the time of that report, 4,901 children were in special classes for the retarded.

In 1959 the Missouri Coordinating Committee for the Handicapped estimated that there were approximately 72,000 physically or mentally handicapped children in that State. At the time of that report, 32,201 children were in special classes.

In 1958 the Maine Commission on Problems of the Mentally Retarded estimated that there were 6,800 retarded children between the ages of 5 and 16 in the State of Maine. Of this number, 400 were in special classes.

The Oregon Interim Committee on Mental Retardation and Emotional Disturbance estimated that in 1958 there were between 6,000 and 9,000 children in that State eligible for placement in special classes for the mentally retarded. During the school year 1958-59, approximately 500 children were in such classes.

The report of the Illinois Commission on Mental Retardation in 1958 revealed that the schools were not providing for 75 percent of the educable mentally retarded children in that State, and were not providing for 93 percent of the trainable mentally retarded children in that State.

In 1957 the Indiana Legislative Study Committee on Mental Retardation estimated that 16 percent of the children suspected of mental retardation were being served in special classes for the retarded.

In 1959 the Kentucky Department of Education reported that 74 percent of the handicapped children of all types in that State were receiving some sort of special service.

Some evidence of the degree to which the States are concerned with this problem is indicated by the fact that between 1956 and 1959 no fewer than 20 legislative or Governor's commissions were functioning in the area of mental retardation alone. Since the time of this report, several additional States have established such commissions.

At a recent conference of national organizations in the area of special education, representatives of a wide variety of agencies quickly delineated areas of common concern. These areas were strikingly similar to the problems confronting the various States as revealed in the reports described earlier.

One of the most pressing of the common problems in the area of special education is the severe shortage of administrative and supervisory personnel at a local and State level. While Public Law 85-926 will do much to alleviate this problem in the area of mental retardation, it will be necessary to broaden the provisions of this law to cover other areas of exceptionality if a program of total services is to be evolved.

In the words of the 1958-59 annual report issued by the Department of Education of the State of Colorado, one factor handicapping expansion of special programs was "lack of sufficient personnel at the State level to provide adequate consultative services when districts

were planning programs. Without consistent advisory assistance during the initial stages of planning a special education program, there frequently has been a delay in the establishment of classes."

The problem of securing adequately trained teachers is mounting in intensity in the field of special education. In 1955 Samuel M. Brownell, former commissioner of education, noted that there existed in the United States on the average, 180 exceptional children for each specially trained teacher.

As educators and the general public become increasingly aware of the tragic waste of human resources represented in our failure to provide necessary services, the demand for adequately trained teachers will be felt ever more keenly. Once again, the extension of Public Law 85-926 will be a positive step in meeting this ever mounting need for adequately trained teaching personnel.

The State of New York, through its training grant program for teachers or future teachers of retarded children, has demonstrated that something can be done about this problem at the State level.

In the 3 years that this program has been in operation, 1,553 awards have been made to 1,027 persons training to teach the mentally retarded. Of these, 1,027 persons, 958 are now teaching classes for the mentally retarded. Seventeen colleges and universities are cooperating in this program, and the continued growth of the program is anticipated.

The success of this undertaking can serve as a guide to other States, not only in respect to training teachers for the mentally retarded, but in reference to training teachers for all exceptional children.

A most pressing problem in the field of special education concerns the development of procedures for the guidance and assistance of less affluent States in respect to the establishment of such a program.

At the conference of national organizations mentioned earlier, it was quickly recognized that all participants were concerned with the problem of early diagnosis and placement of exceptional children. Whereas in 1949 not a single specialized clinic existed for the diagnosis of the mentally retarded, at the present time there exists over 70 such clinics.

To meet the need in the area of the mentally retarded alone will necessitate the further allocation of funds to the U.S. Children's Bureau for the expansion of such clinical facilities for the mentally retarded, and for the development of traveling clinics to serve the often neglected rural areas of the United States.

In view of the generic need for early diagnosis and placement, which characterizes all exceptional children, and in view of the multiplicity of handicaps which occur, there is a great need for the establishment of procedures for the coordination of the activities of these clinics with the programs of the public schools and other public agencies.

Early placement of handicapped children is as vital as early diagnosis. In the area of the mentally retarded, the State of Massachusetts, through the 24 nursery training centers operated for preschool retarded children, has demonstrated the effectiveness of such a program. What has been done in Massachusetts for preschool mentally retarded children can be done in other States and for other exceptionalities.

Of vital concern is a recognition of the need for the establishment of minimum standards in the area of diagnosis, teacher certification requirements, and course content at institutions of higher education.

A recent survey of State certification requirements in special education reveals 7 States with no special standards, and 43 States with standards in at least one area. While since 1954, 11 States have initiated certification requirements in special education, and 22 States have revised their standards, examination of the results of the survey reveals wide diversity in the number of credit hours required by different States for certification of teachers in specific special areas.

The report indicates, "It should be noted that only in the area of speech and hearing therapy do the recommended standards of a professional organization (American Speech and Hearing Association), have a noticeable impact upon consistency of amount and degree of training required."

Not only does this diversity result in confusion in the minds of potential teachers, but it serves to erect barriers between States where none need exist. Thus, a person qualified to teach retarded children in California, may be unable to secure certification in New York in spite of the fact that both States have outstanding programs. In this age of mobility, the seriousness of this problem cannot be too greatly emphasized.

The development of regional groupings has indicated that such a regional approach possesses tremendous potential for overcoming many of the problems in reference to teacher education and the provision of direct services to children. This potential has already been demonstrated by the activities of the Southern Regional Education Board.

Operating on a philosophy that the member States by themselves may develop ineffective programs, an attempt is being made to develop regionwide services. Participants in this development are representatives from Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

In States which are essentially nonurban in nature, a similar approach is underway through the activities of the Western Interstate Commission for Higher Education.

Nowhere is guidance and assistance more sorely needed than in the area of the development of work training programs for mentally retarded adolescents. A recent survey of public school systems having classes for the mentally retarded at the secondary level, reveals that less than 10 percent of such children remained in school through the 12th school year.

The major needs indicated by the school systems surveyed appeared to be in the area of the development of work training programs. When one considers that retarded children need more, not less preparation for adult life, the revelation that 10 percent or less of such children remain in school through the 12th school year, makes the development of such work training programs of vital importance.

Successful programs are, to mention but a few, in operation in Detroit, Mich., Jacksonville, Fla., and Santa Barbara, Calif. In their

totality, however, the existing programs are the exception rather than the rule, and are far from meeting the known needs in this area.

As a result of the splendid legislation enacted by Congress in the area of vocational rehabilitation, the past few years have witnessed a gratifying increase in the number of sheltered workshops and vocational training facilities available to the handicapped.

The Office of Vocational Rehabilitation has demonstrated its awareness of the need for establishing the closest possible working relationships with those in the field of special education. There is every indication that the need for close liaison between the Office of Vocational Rehabilitation and the Section on Exceptional Children and Youth of the Office of Education, will mount in intensity.

In reference to all the problems I have outlined above, one vital course of action is the development of additional staff resources for the Section on Exceptional Children and Youth. It has been amply demonstrated that attempts are being made at the State and local level to serve the children with whom we are here concerned.

What is needed is the guidance of these activities by some agency capable of developing consensus in reference to problems of administration, teacher recruitment, financial procedures, certification, et cetera.

That agency is the Section on Exceptional Children and Youth of the Office of Education. An example of the type of leadership contribution which the Section on Exceptional Children and Youth and the Office of Vocational Rehabilitation can make, has been demonstrated in the outstanding service rendered by these two agencies in their development and publication of the booklet, "Preparation of Mentally Retarded Youth for Gainful Employment."

The Governor's commissions exist, the regional organizations are growing, the public is alerted. Guidance from a Section on Exceptional Children and Youth capable of developing close ties with the Office of Vocational Rehabilitation, capable of providing consultative services, capable of developing institutes and conferences, of sponsoring surveys, of issuing bulletins, and capable of stimulating leadership at all levels, is now more than ever before, vitally needed.

The responsibility for the effective utilization of the potential of the exceptional child rests ultimately with the State, the local school district, and the local community. Leadership from the Children's Bureau, the Office of Education, the Office of Vocational Rehabilitation and other Federal agencies, through consultative services and through the stimulation of the type of activities I have described above, can do much to develop community recognition that the exceptional child can make a contribution to the welfare of the community, the State, and the Nation.

Mr. DANIELS. Thank you very much, Dr. Charney, for that very fine statement.

I know a great deal of work has gone into it. We appreciate your coming here.

Mr. CHARNEY. Thank you.

Dr. BARNARD. Mr. Chairman, I would like to ask that at this time the statement of the Reverend Richard M. McGuinness, director of the Mount Carmel Guild Center for the Blind, 99 Central Avenue, Newark 2, N.J., be made a part of the record.

Mr. DANIELS. Without objection, the statement will be made a part of the record at this point.

(The statement referred to follows:)

STATEMENT OF REV. RICHARD M. MCGUINNESS, DIRECTOR, MOUNT CARMEL
GUILD, NEWARK, N.J.

I should like to express my thanks to this subcommittee for allowing me to testify today. My own interest is with the legislation connected with work for the blind. For 5 years I have been director of the Mount Carmel Guild Center for the Blind, located at 99 Central Avenue, Newark, N.J.

This centers offers educational, recreational, and social opportunities for blind persons regardless of race or religion. At present we have over 800 blind members who live in Essex, Bergen, Union, and Hudson Counties.

Our activities are rehabilitative in the sense that we believe they will aid in making the blind persons who participate in them more active and independent. Activities at present include, in addition to our social meetings, classes in bowling, braille, script, ceramics, jewelrymaking, sewing, carpentry, radio, dancing, cooking, and home nursing. We publish a newsletter in print and braille and transcribe tape recordings of various magazines each month.

I have read the report of the Workshop on Special Education and Rehabilitation of the Blind held in New York, N.Y., on October 27 and 28, 1959, and given to the Subcommittee on Education and Labor of the U.S. House of Representatives and wish to express my agreement with the views there expressed.

The aim of all work for the blind, both in the field of special education and in the field of rehabilitation, is to render the blind person capable of living as independently as possible. In my opinion independent living will never be achieved unless the handicapped individual's right to make decisions, choices, and mistakes for himself is respected.

I do not pretend to have the answer to the problem of guaranteeing this right in the best possible way. But I raise the question I do not believe we can help a person become a mature, independent, contributing member of society if someone else is making all his decisions for him. In order to help him assume responsibility for his own future, I should recommend that wherever possible Federal or State funds be given directly to the individual, so that he himself purchases the educational or rehabilitative service he requires. The money would have to be given in such a way that it could be used by the individual only for such services, not for other purposes.

In this way, the blind individual would go to a public or private agency, not as a client with hat in hand looking for a service, but rather as a prospective buyer who wishes to purchase a service.

I do not know if such an approach can be worked in all cases, but I do think it at least expresses an attempt to implement the philosophy that all workers for the blind subscribe to: that it is the blind individual who counts, and that he should be helped to become as independent and active a member of society as possible.

Mr. DANIELS. I would like to call at this time as a witness the Reverend D. Roland Gerhold.

Reverend Gerhold, will you state whom you are representing here today?

STATEMENT OF REV. C. ROLAND GERHOLD, NEWARK, N.J.

Dr. GERHOLD. I am one of 40 missionaries to the deaf under the Board of Missions to the Deaf, Lutheran Church, Missouri Synod, 210 North Broadway, St. Louis, Mo.

I have served as pastor to the deaf for 12 years in all New England States and now in the State of New Jersey I am presently pastor of St. Matthew's Lutheran Church for the Deaf in Newark.

I preach to the deaf in eight of the major cities in New Jersey.

I conduct religious training education programs, Bruce School, Newark, North Jersey Training School for Girls—mentally retarded—NJSD, in West Trenton.

I am on the board of trustees of Gallaudet Home for the Deaf, under the Episcopal Diocese of New York, northern and southern New Jersey.

I am spiritual adviser of chapters of the Protestant Guild for the Deaf, a nonprofit organization of hearing and deaf, with the purpose of serving the deaf, by learning to know and understand them, by aiding the deaf to obtain jobs, by visiting the deaf in institutions, by educating hearing people to the needs and problems of the deaf.

Mr. DANIELS. How do you find time to devote all your time to all these activities?

Dr. GERHOLD. I don't. I do have an assistant, though. I am for the passage of H.R. 494.

I was here yesterday and in all the testimony about the need for qualified teachers of the deaf and other trained workers assisting the deaf toward overcoming their problems, let us not forget the great problem of communication.

Related to this is the social language of the deaf, gestures, signs.

From experience and research, most educators of the deaf agree to three major groupings of educable deaf—I stress the word “can”:

1. Those who can learn solely by the oral method.
2. Those who can learn only by signs.
3. Those who can learn by the combined oral-sign methods.

Though educators and psychologists may present varying percentages for these groupings, the majority group is, those who can learn by the combined method.

To this group we add those who cannot learn by the oral method, but by signs only. This group, some have estimated from 60 to 85 percent of all the deaf. This larger group uses the signs as a social language.

Communication is a two-way path. The deaf communicate with hearing people, using their speech, which they have in varying degrees, and their social language.

In order for selected representatives of the hearing world to understand the deaf in school and adult life situations, the ability to use the sign language for sending and receiving information is necessary.

Several fine books are available. These describe the signs as well as picture them, but they are inadequate, for the sign language is fluid, and as such must be demonstrated in order to learn it.

One of my responsibilities is teaching sign language to new members on the staff of the New Jersey School for the Deaf in West Trenton. You can realize the 50 percent stressed by Miss Titsworth yesterday of new teachers without a background in the techniques of the deaf that this would be one of my interesting contacts.

Permit me to quote from Dr. J. Schuler Long's “Sign Language Manual,” page 107. This manual is used at Gallaudet College in Washington, D.C., the only college for deaf in the world:

Good: * * * Place the end of the palm against the mouth; then bring it down against the open left hand so the back of the right hand rests in the palm of the left.

Bad: * * * Same position of the hand as in “good.” In bringing the hand away, draw it slightly toward the right, turn it palm down and throw the hand downward.

Now I demonstrate.

An agency of our Government provides educational material for the blind, transcribed in braille and sound. Recently one agency has entered the field of captioning outstanding movies and making them available to deaf clubs.

I propose to your committee, therefore, that it consider allocating a portion of the funds for teacher education outlined in the bill, H.R. 494, for producing an instructional sign language film.

Copies of this film would assist teachers for the deaf, supervisors, and house parents; as well as parents of deaf children in learning the signs. We know that parents do not need signs to understand their children or be understood by them, but when they meet their children's deaf friends, they will want to understand and be understood by them.

Such a film would assist the personnel of private and Government agencies in acquiring the sign language, thus broadening their attempts at resolving the problems of the deaf.

Thank you.

Mr. DANIELS. Reverend Gerhold, are any such films in existence at the present time?

Dr. GERHOLD. I know of none, not even down at Gallaudet College.

Mr. DANIELS. But you make this recommendation?

Dr. GERHOLD. I certainly do.

Mr. DANIELS. This is based on your experience?

Dr. GERHOLD. Based on my discussions with the consultation department at the New Jersey School for the Deaf, at other schools where teachers have found the need of learning the sign language.

It just is impossible to have enough interpreters present or to learn through deaf people or interpreters the signs.

Mr. DANIELS. These will be used for educational purposes on the elementary school lines, or advanced stages of education?

Dr. GERHOLD. This would be used with the educators themselves and I feel they would be used by departments of rehabilitation and also in U.S. Employment Service to train their personnel.

Mr. DANIELS. Are there any questions?

Thank you very kindly.

Dr. GERHOLD. Thank you, Mr. Chairman.

Mr. DANIELS. Our next witness is Mrs. Teresa D. Carroll, supervisor of classes for children mentally handicapped, public schools of Jersey City, N.J.

STATEMENT OF MRS. M. TERESA D. CARROLL, SUPERVISOR OF CLASSES FOR CHILDREN MENTALLY HANDICAPPED, PUBLIC SCHOOLS OF JERSEY CITY, N.J.

Mrs. CARROLL. Mr. Chairman and members of the committee, I bring you greetings from Dr. James E. Reynolds, superintendent of schools of Jersey City, and Mr. Vincent O'Shea, assistant superintendent of schools, who is in charge of the entire field of special education, Jersey City.

New Jersey is 1 of the first 13 States in the Union to pass mandatory laws for the training of the mentally retarded children. Jersey City opened its first class in that same year, which was 1911.

We at the present time have 29 classes for the training of the mentally retarded. Twenty classes are for the training of the educable retarded child and nine for the severely retarded.

With a population of somewhat over 300,000 in the city, we feel that great strides have been made in this field of special education in Jersey City, but with all we don't feel that we are entirely meeting the needs.

There is a great deal yet to be done. Children living in a democracy have a right to expect equality of educational opportunities.

Unmet needs in the field of special education are in conflict with democratic precepts.

Now, in order to remedy these unmet needs, we feel that the beginnings are in the colleges where sufficient funds are needed for them to inaugurate complete programs for certification in the field of special education.

Not to many of the colleges have complete courses for this certification at this time. Many of them have a few courses, but not too many have courses that would lead to complete certification.

Then colleges need money in order to offer scholarships to encourage students to become interested in the vitally needed areas in special education training. Money is needed to aid school districts for the purpose of creating additional special classes for handicapped children which would give these children the equality of opportunity which is presently denied them in education.

Money is needed to provide adequate rehabilitation services for these children.

Then sufficient sheltered workshops wherein work capacities can be evaluated and developed particularly when individuals cannot be absorbed in the competitive labor market. There are very few of these sheltered workshops in existence in proportion to the need. In Jersey City we have one privately organized workshop, but it is not a sheltered workshop. It would take care of the educable mentally retarded, but so far to this point we haven't any arrangements for the severely handicapped child who leaves school and has no means of furthering his education.

We cannot afford to deny these children the training they rightly should receive or to reject the services that they can render.

In addition transportation and luncheon facilities are needed to implement this program.

I am very grateful to you for allowing me to give my report.

Mr. DANIELS. Thank you very much for coming here, Mrs. Carroll, and giving the committee the benefit of your statement.

Mrs. CARROLL. Thank you.

Mr. DANIELS. Our next witness is Eleanor J. Carlin, associate professor, division of physical therapy, School of Allied Medical Professions, University of Pennsylvania.

STATEMENT OF ELEANOR J. CARLIN, ASSOCIATE PROFESSOR, DIVISION OF PHYSICAL THERAPY, SCHOOL OF APPLIED MEDICAL PROFESSIONS, UNIVERSITY OF PENNSYLVANIA

Miss CARLIN. Thank you, sir.

I have a prepared statement which I will submit with your permission, and ask for only half of my 10 minutes to outline a few

points which I feel have not been brought out in relation to this statement.

Mr. DANIELS. Without objection, your prepared statement will be filed in the record following your oral testimony.

Miss CARLIN. Thank you, sir.

I represent actually the field of physical therapy and somewhat indirectly the field of occupational therapy.

I think perhaps you realize that my prepared statement, having heard all the testimony I have heard today and what you must have heard in the last few days, deals primarily with the personnel shortage. I think it has become quite an obvious fact that this is a real and unmet need in the health care of our citizens.

I feel there are one or two points which might be brought out here to you this afternoon which may highlight some of the approaches to the personnel shortage.

One of the most important things I feel has not been said is that the personnel to fill this personnel shortage exists. We do not have 180 million people in this country for nothing, and we are getting more and more of them every day as the maternity wards—

Mr. DANIELS. We should encourage people to follow this profession?

Miss CARLIN. It is more than an education. I think we must first inform them. I think we are taking for granted that the people know that profession exists in the first place.

I think one of the biggest unmet problems we have right now is a total crash program of propaganda, information to the general public, not just to the school child.

Mr. DANIELS. Do you think it is the role of the State or Federal Government?

Miss CARLIN. The Federal Government and State governments, both have a responsibility in this.

One thing that has been lost sight of, Mr. Daniels, is that during the years of 1941 to 1943, we did this. We needed to double our numbers of physical therapists in the country and we did it. We got the numbers in 2 years that it had taken us 25 years to establish.

We did it because there was a reason for it. I think this same thing could be done at the present moment.

I believe this is true in almost all the related and allied medical personnel groups that we are dealing with as far as shortages are concerned.

The point to my statement is that I would hope that some consideration could be given to a total program of informing the general public of the existence of these professions.

I think that when you get more people aware of them you will have more people coming in these professions.

I think the second point I would like to make, and this was brought up this morning and I wish to speak to it, there were several people who mentioned it.

One of our problems in the personnel shortage is salaries. I am not entirely convinced this is the answer. I am not sure we can buy people for these professions.

I would hope, sir, that we have not yet reached the stage in this country where what you make is the only thing that sends you into a particular profession.

I can say from my own experience in having taught physical therapies for many years that the student's first concern is what he is going to make, is a second-class physical therapist.

I am convinced we have people who are service oriented in this world. When you have a more informed general population, you will have more persons who will come to work at an equitable salary, but we do not have to think constantly in terms of raising salaries in order to fill this personnel shortage. This has to stop someplace, or else we will price ourselves out of existence.

Mr. DANIELS. In some States and in some areas the salaries are very low.

Miss CARLIN. I agree with you. When I used the word "equitable," I meant there must be a base limit to these as well, but I don't think we can just take the attitude by raising all salaries of medical personnel you will get more people. I don't think that is the answer at all.

Mr. DANIELS. And you will not necessarily get the best qualified talents.

Miss CARLIN. That is right. I have heard mentioned several times in the testimony this morning our workshop in Philadelphia, a cliché, if you will, of how to solve the whole problem, by putting in non-professional personnel.

I would like to go on record as being very strongly opposed to the utilization of nonprofessional personnel to fill this so-called personnel shortage.

Everyone in this room is, I am afraid, some day going to need the services of the physical and the occupational therapist, the medical technologies and the doctor. I would not wish someone half trained to work on me. I am sure no one in this room would, either.

I think if we go back to our original basic point that if you inform the public this exists, you will get the people interested in it, and there will be no need for the fourth-class technician doing the job which the first-class professional must do.

Thank you for your courtesy, gentlemen.

Mr. DANIELS. Thank you. You have had a great deal of patience in waiting this late in the afternoon to testify. We do appreciate your coming here and giving us the benefit of your ideas and thoughts on this very important subject.

Miss CARLIN. Thank you, sir; it has been my pleasure.

(The formal statement of Miss Carlin follows:)

FORMAL STATEMENT OF ELEANOR J. CARLIN, ASSOCIATE PROFESSOR, DIVISION OF
PHYSICAL THERAPY, UNIVERSITY OF PENNSYLVANIA

The statement which I wish to present is primarily concerned with the fields of physical and occupational therapy, as they relate to the overall area of rehabilitation. In assessing the most urgent and unmet needs of these fields, one primary factor stands out vividly. The most urgent need is that of securing and training more young men and women to become qualified physical and occupational therapists.

Granted that thousands of citizens in need of rehabilitation exist, the fact remains that no survey, no additional buildings, and no expansion of facilities is of any value unless trained personnel can be secured to administer treatment.

We have at present a rapidly increasing number of rehabilitation centers, both public and private, being established throughout the country. Numerous centers which have been in existence for many years are expanding their

physical plant or planning to expand it. In the four States concerned in these hearings (Delaware, Maryland, New Jersey, and Pennsylvania) we have presently adequate training facilities for physical and occupational therapy students.

The problem really revolves around the fact that the existing facilities are, for the most part, unable to secure adequate staff and none of the schools has full enrollment.

It would appear that to continue to expand centers is unrealistic until some assurance can be given that adequate personnel will be available to staff them. Referring to the "independent living" proposal, it has great merit and represents a real need for a large segment of our population. But the objectives of this bill will be realized only when sufficient numbers of trained people are available to implement it. More and larger buildings are far from the answer to the problem.

What is needed is a national emphasis on recruiting young men and women into these fields and increased financial help to assure them of qualified training. In a sense, a total push program of information, publicity, and propaganda to familiarize the general public with the opportunities these careers present must be instituted at the earliest possible date.

We must recognize the fact that the general public is still totally unaware of many of the professions allied with medicine. It is not merely a question of recruitment, but first the need to introduce these professions and to emphasize the contribution they will be called upon to make to the general health of our Nation.

The present total enrollment in the 39 approved physical therapy schools is 706. This, in a Nation of nearly 180 million is a pitifully small number. It has been conservatively estimated that we should be enrolling 3,000 each year. But this cannot be realized until the public is informed. This would represent one vital service the Federal Government could provide to answer the most basic unmet need of our health and welfare services.

Mr. DANIELS. Our next witness is Mr. James M. Robins, chairman of the Legislative Committee, National Association of Social Workers, Newark, N.J.

You may proceed.

STATEMENT OF JAMES M. ROBINS, REPRESENTING THE NORTH JERSEY CHAPTER OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

Mr. ROBINS. I am James M. Robins, representing the North Jersey Chapter of the National Association of Social Workers.

Our association is pleased to testify at this hearing, which we feel will result in a valuable contribution to the field of rehabilitation. The committee is to be commended for its interest in helping people and for its attempts to obtain pertinent information which will enable it to make an objective decision.

Social achievement of self-sufficiency on the part of the severely disabled individual is basic. Physical restoration of the individual to the point where he can take care of his own needs and thus relieve the family of a constant burden will promote a happier existence for the individual himself and the family. An important part of the program is that the individual, who has been in constant attendance caring for the needs of the handicapped person, will be relieved to the point where he may very well be available for outside employment.

Of significance is the development of the sense of self-worth and a feeling that a disabled individual is carrying his share of the responsibility within the family unit, thereby restoring the human dignity which is essential to our way of life.

Seriously to be considered is the prevention of the institutionalization of some of these persons, thus saving badly needed space for

others. It is conceivable that the future expenditures for capital investment for new institutions can very well be curtailed as a result of providing independent living. Such individuals will remain in the home rather than be placed in an institution, which will result in savings to the taxpayer.

We can recognize together that the proposed appropriation essentially allows for a demonstration of an idea which we hope will later warrant an increased appropriation.

Rehabilitation is a concept which must pervade all fields of services: public health, public welfare, and vocational rehabilitation. The NASW carefully appraised this proposed legislation through consultation with representatives of the various units of the Department of Health, Education, and Welfare and in a conference of representatives of the American Hospital Association, American Medical Association, American Public Health Association, American Public Welfare Association, and the National Rehabilitation Association.

The association's conviction as to the importance of programs geared to assisting the handicapped individual in achieving a maximum of independent functioning is emphasized in the various statements published by our association.

Our association holds that the most desirable legislation at this time is to provide substantial Federal participation in State and local demonstration projects which under proper Federal-State-local coordination would encourage and strengthen health, vocational rehabilitation, and welfare programs designed to assist the severely handicapped.

We extend our best wishes to the committee in working out a program which will increase the happiness of disabled individuals and lessen the burden for their families.

I might add in our own field of social work there is a shortage of personnel and it is important to train personnel that will fit into this program of independent living.

We extend our best wishes to the committee in working out a program which will increase the happiness of disabled individuals and lessen the burden for their families.

Thank you.

Mr. DANIELS. Are there any questions, Mr. Chairman?

Mr. ELLIOTT. Except to say, as is always true, I have enjoyed the very able statement of the gentleman who has spoken to us, Mr. Robins.

Mr. DANIELS. Thank you very much, Mr. Robins.

Mr. ROBINS. Thank you.

Mr. DANIELS. I believe our final witness of the day is Mrs. Donald B. Hurwitz. I do not know if we have overlooked anyone. Is there anyone present in the audience who desires to testify before this committee? If not, I wish to express my thanks and gratitude of the committee to all persons who have come here to give us the benefit of their ideas and views in this very important field of special education and rehabilitation. Thank you very much.

(The following statement was submitted:)

STATEMENT OF GRACE E. MILLS, PROGRAM CONSULTANT, CONNECTICUT CHAPTER,
NATIONAL SOCIETY FOR THE PREVENTION OF BLINDNESS

It is the thought of our group, the Connecticut Chapter for the Prevention of Blindness, that the education of the partially sighted child has not been adequately emphasized. Provisions for training and educating the legally blind have been made but the partially sighted group have not been given adequate consideration. The problems of the partially sighted differ from those of the blind so special services are needed for their education and vocational guidance.

1. A recent spot check survey by the National Society for the Prevention of Blindness revealed that 1 child in 500 of the school population should be classed as partially sighted or visually handicapped. There are very good statistics available on the legally blind, but the statistics on the partially sighted are very inadequate. The need to recognize and classify this special group is great. At present, the limited vision group includes:

- (a) The legally blind who use print.
- (b) The legally blind who use braille.
- (c) The partially seeing who have a corrected vision of 20/70 or less.
- (d) Any individual who requires special education or rehabilitation, in the opinion of a qualified committee.

The term "limited vision" should be expanded to include all visually handicapped who are limited either vocationally or educationally because of ocular pathology or refractive defects and who need the special services.

One of the most pressing unmet needs in the relation to the education of partially seeing children is the provision of expanded educational services. Implied in this need is the initiation of new services in many of the smaller communities and rural areas, the evaluation of present services, and the expansion of services in the secondary schools.

Based on the ratio resulting from the studies made some years ago, which indicated approximately 1 child in 500 comes within the definition of partially seeing, it would appear that currently there are some 78,000 partially seeing children. Records in the office of the National Society for the Prevention of Blindness show that presently 8,200 are receiving this much needed educational service.

Connecticut has an enrollment of 447,778 schoolchildren. Based on the above ratio, it follows that 895 children need special services. At present, only five formal classes fulfill this need in the State. Joint efforts of private agencies and official groups can contribute much to the welfare of these children by stimulating the expansion of services.

Since the partially sighted group is much larger than the legally blind the demand for qualified personnel in the specialized fields is great. There is a general shortage of specialists in this field—i.e., teachers, social workers, rehabilitation counselors, doctors, nurses, psychologists, psychiatrists.

Funds to recruit and train such personnel should be available under the National Defense Act.

2. Since many ocular defects are readily remediable in early childhood, there is a great need of case finding in infants and preschool children with visual defects. These same defects, if not discovered early, may be resistant to all forms of treatment during the rest of the individual's life. It is recommended that Federal funds be allotted for research in the development of more adequate and effective methods of screening in these areas.

3. The usual 1- or 24-point type now being used in materials printed by the American Printing House for the Blind is not equally effective for all partially seeing persons. Research to determine what type sizes are most useful to the visually handicapped is needed. Federal funds should be allotted for this research.

4. Federal funds to support expansion and coordination of effort in the clinical programs for the use and development of low vision aids are needed. Low vision aids have helped many partially sighted individuals to have useful vision.

5. The lack of rehabilitation centers to provide services for the partially sighted is a serious problem which should be called to the attention of the committee. More knowledge and guidance is needed to provide appropriate services in centers where the partially sighted might have family counseling, vocational train-

ing, and a complete evaluation as an individual in his quest for independent living.

6. Provision should be made for the expansion of existing private workshops or the creation of new ones to provide remunerative employment for the partially sighted who cannot be absorbed into private industry. These workshops should provide evaluation of work potential, development of work capacity, remunerative employment, and placement.

7. There is a need for the extension of special educational supplies and equipment to service any partially seeing individual in need of some of the supplies now provided by the Government only for the legally blind. It is recommended that any visually handicapped individual requiring special services should have available all existing materials purchasable on quota account from the American Printing House for the Blind.

8. Since there is a shortage of trained personnel needed to effectively carry out a program of education and rehabilitation for the partially sighted, it is recommended that—

(a) Federal funds in the form of grants-in-aid as scholarships, fellowships, or traineeships to colleges, universities, and specialized schools be made available (or increased) in order to train qualified personnel.

(b) That Federal funds be allocated for financial assistance to colleges, universities, and specialized schools to include in their curriculums, essential courses dealing with the problems of the partially seeing.

(c) That Federal funds be allotted for the provision of inservice training seminars, intensive short-term training, and workshops for practitioners in the various disciplines as well as for administrators.

9. It is the hope that our chapter and the National Society for the Prevention of Blindness can cooperate in such needed projects as—

Those related to research:

(a) To investigate the validity of the present estimate that 1 child in 500 is partially sighted.

(b) On current teaching practices.

(c) On current educational planning and programing, to determine advantages and disadvantages.

(d) To determine the quality of present teacher preparation programs by their on-the-job effectiveness.

(e) Continuation of the U.S. Office of Education research to determine teacher competencies.

(f) Continuing collection of statistics on the number of partially seeing children.

Those related to interprofessional education:

(a) Cooperation with the NSPB in arranging for conferences and workshops for health and education personnel to acquaint them with the educational, social, psychological, and vocational problems of the partially seeing and to provide opportunity to discuss ways and means of helping these children in schools and in preparation for job training.

Those relating to such measures as implementing:

(a) Increased funds from Government sources to permit production of greater quantities and varieties of needed educational materials such as larger type books.

(b) Provision of funds for teacher preparation scholarships and trainee-fellowships for advanced studies in the field of the partially seeing.

Respectfully submitted for your consideration.

Mr. ELLIOTT. This completes our list of witnesses. However, before adjourning I would like to, once again, express my sincere appreciation to Congressman Daniels, Mr. Gangemi, Sheriff Flannagan, and all of the many others here in Jersey City who have contributed so much toward making these hearings a success. I am sure I bespeak the sentiments of the entire subcommittee and our staff when I say that our stay here has been most enjoyable, enlightening, and worthwhile.

The subcommittee is now adjourned.

(Thereupon, at 4:25 p.m., the hearing was adjourned, subject to the call of the Chair.)



